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Francis Edward Mitchell

**Management of Perceptions of Fitness for Purpose in
the Education of Mental Health Nurses.**

DOCTOR OF EDUCATION (EdD)

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Abstract

Management of perceptions of fitness for purpose in the education of mental health nurses.

This is a study into the present arrangements for the management of the education and training provision for mental health nurses prior to registration known as Project 2000.

The primary aim of the research was to determine how the perceptions of the stakeholders could be managed in relation to delivery of appropriate educational preparation.

This work utilised a case study research methodology. Thirty subjects were interviewed from a variety of stakeholders in mental health nurse education. The study used an innovative interview method involving techniques borrowed from the therapeutic interventions of Neuro Linguistic Programming, in particular, rapport skills and some specific focused questioning techniques. The data were analysed utilising a phenomenological approach to examine the lived experience of the subjects.

The findings of the study showed that there exists a specific set of knowledge, skills and attributes which are regarded and agreed by all of the stakeholder groups as being vital to mental health nurses. The findings related to knowledge, skills and attributes matched fairly closely with the published literature on the topic, but were of a much more specific and very basic nature. It was also found that although all of the stakeholder groups were in broad agreement about the simple and basic nature of the knowledge, skills and attributes required, each of those groups was of the opinion that their views were not shared by other stakeholder groups.

The study concludes by examining potentially useful ways of managing the perceptions of the stakeholders. The establishment of the role of mental health liaison officer is discussed which, it is argued, might enhance the ability of educational institutions to manage the delivery of educational

programmes based upon a detailed knowledge of the perception of the stakeholders. It is further concluded that the interview skills described in the study would be potentially of value to other researchers using interviews as an investigative tool.

Chapter 1 - Introduction

This is a study into the present arrangements for the management of the education and training provision for mental health nurses prior to registration known as Project 2000. It focuses on the notion of 'fitness for purpose' – defined (see below) as whether an individual nurse is able to function competently in practice.

My interest in the management of perceptions of fitness for purpose in the education of mental health nurses as an issue to research began in 1993 when I was newly appointed as head of pre-registration nurse education at Northland College of Health Studies. One of the first formal activities I was involved in was the validation of the first Project 2000 course to be run by Northland College.

In my previous role as head of post registration studies in two different colleges of health studies, I had led teams through the creation, submission and validation processes of post registration courses by the English National Board for Nursing & Midwifery (ENB). The Project 2000 course validation event was the first con-joint event between the ENB and a university that I had experienced.

I was struck by several differences in style of the validation event. The number of people on the validation panel was around 20, whereas previously I would have expected five or six. The atmosphere was quite confrontational rather than the exploratory type of discussion I had previously experienced with the ENB.

The nature of the information being questioned was also quite different. Rather than being focused upon how the course would impact upon practice, the panel's concerns seemed to centre around whether the proposed course was appropriate to diploma level education and whether the nurse teachers were capable of delivering a course of that academic standard. There appeared to be a shift in emphasis from fitness for practice towards 'fitness for award.'

The course was approved, albeit with numerous conditions, most of which centred around a partnership agreement being drawn up between the college of health studies and the university which specified a substantial number of hours teaching by university staff.

Between 1993, and 1996, as part of the Government's *Health of the Nation* Strategy all nurse education moved from Department of Health, hospital based colleges of health studies into universities. New arrangements were made for the commissioning and quality assurance of courses, which included the establishment of education and training consortia. In my role as head of pre-registration nurse education, I was involved in the major negotiations necessary to facilitate the merger with the university and the development of training contracts and working arrangements with the new consortium.

During this period I became aware of tension developing between the university's drive to ensure the quality of academic standards and the consortium's drive to ensure that they were receiving 'value for money' education. The consortium's agenda appeared to be based upon the university delivering a contracted quantity of education and based upon agreed quality standards.

The contracting cycle was developed during this time, which tied in the commissioning of a specified number of qualified nurses with the human resources planning strategy of the local NHS trusts (as represented by the consortium).

Initially, the agreed quality standards more closely resembled *quantity* standards, as they were concentrated upon numbers of students per intake, attrition and completion rates. The standards did, however, evolve through discussions at contracting meetings to include some early ideas around fitness for purpose. For example, in the mental health field, one of the local NHS Trusts had raised the issue that more qualified nurse therapists were required, and an agreement was reached about how many were needed and

how they should be prepared. Specific details regarding the quality of the delivery of the courses, however, were left to the university to determine.

Preparation of nurse teachers for the merger with the university at this time was a really important issue. The nurse teachers felt that they needed to develop academic expertise and credibility to ensure their employability once the merger with the university had taken place. A concentrated programme of staff development was undertaken which was aimed at encouraging the nurse teachers to develop academic subject expertise and to pursue masters' level study. Once again, the push here was concerned with fitness for award, or more specifically, the fitness of the nurse teachers to deliver programmes that were at university diploma level.

The legitimacy of spending large amounts of time working in clinical areas was beginning to be questioned by the university, and the perceived value of clinical credibility appeared to be diminishing.

The merger with the university was completed in 1996, at which time I took up post as head of pre-registration studies on a 2 year fixed term contract. From 1996-1998 I was again involved in the contract monitoring meetings with the consortium.

During this period I became aware that a shared understanding had developed between the consortium and the university about the nature of fitness for award. The consortium appeared to trust the university to monitor and maintain academic standards. Fitness for practice was a fairly clear issue, in that it is defined by the meeting of competences specified in the Nurses Act. Fitness for purpose, however, appeared to be a really difficult concept to define.

There was much discussion at the contract monitoring meetings around the expectation of the trusts that nurses, at the point of qualification, would be fit for purpose, whatever that purpose might be. A term often used to describe this expectation was that upon qualification nurses should be able to 'hit the floor running'.

There seemed, however, to be a wide range of different and sometimes conflicting perceptions as to what being fit for purpose actually meant in terms of knowledge, skills and attributes. In my role as head of department, I was involved in discussions relating to how the content of the curriculum could be modified to attempt to ensure fitness for purpose. During my two years in post, although there was substantial effort devoted to resolving this issue, no answer was ever found. The difficulty seemed to be around the definition of fitness for purpose, which appeared to be almost impossible to establish. Different people seemed to have their own individual view of what this meant.

This raised the question of how a curriculum planner could construct a course that met fitness for purpose criteria when they were so diverse. The differences in perception were apparent even within nursing specialities. For example in mental health, fitness for purpose at the point of qualification could mean something very different if the newly qualified nurse intended to practice in hospital or in community. There would also be differences if the nurse intended to practice in an acute psychiatric admission ward, or in an elderly care scenario.

It seemed to me that managing the perceptions of the stakeholders was a really key and interesting issue which was worthy of in-depth research. If, as I believed at the time, the perceptions were so diverse and sometimes contradictory, was it possible to construct a course that would be able to satisfy the stakeholders that fitness for purpose criteria were being met?

The term stakeholder, as utilised in this study, is defined as

“a person such as an employee, customer or citizen who is involved with an organization, society, etc. and therefore has responsibilities towards it and an interest in its success.” (Cambridge Advanced Learners’ Dictionary Online)

<http://dictionary.cambridge.org/define.asp?dict=CALD&key=77368>

When I moved out of pre-registration nurse education in 1998, the opportunity to study the management of the perception of the stakeholders, without being directly involved in the process presented itself.

My judgement was that looking at nurse education overall would be too wide a brief for the time and resources available to me to undertake the research; therefore I decided to narrow the focus to mental health which is my own field of nursing.

I hoped to discover ways of finding out what fitness for purpose means to those individuals and organisations that have an interest in the content of mental health nurse education and a legitimate claim that their needs should be met by the courses run by the university. These individuals and organisations are referred to as stakeholders throughout this study.

Once I had found how stakeholders perceive fitness for purpose, I wanted to then find ways in which this knowledge can be utilised to ensure that the university can produce courses that meet the stakeholders' perceptions of fitness for purpose.

Focus of the Study

The present arrangements for the management of the education and training provision for mental health nurses prior to registration known as Project 2000 were developed by the United Kingdom Central Council for Nursing Midwifery and Health Visiting (1986). The ENB was superseded in April 2002 by the Nursing and Midwifery Council (NMC), however, the empirical data for the study was obtained prior to this change.

The National Health Service (NHS) has been the subject of many changes and reforms in recent years. In addition to this, the nature of nurse education has itself been subjected to major change. The study examines the nature of the changes affecting both the NHS and nurse education in general, and assesses in terms of a variety of perspectives, the extent to which there is a match

between the need for nurse education and the current provision. The emphasis, however, is specifically geared towards mental health nursing.

The three notions of fitness as utilised in this study are defined as follows:

1. Fitness for Practice is used to describe the endorsement by the professional bodies that an individual has met, and is continuing to meet` nationally laid down standards by the United Kingdom Central Council for Nursing Midwifery and Health Visiting (1999)
2. Fitness for Purpose is used to determine whether the individual nurse is able to function competently in practice.
3. Fitness for Award is used to assess whether the academic level of the education of nurses is appropriate for the award of university diploma or degree.

Whilst the main concern of the Statutory Bodies would appear to be fitness for practice as detailed in the *Fitness for Practice* report, United Kingdom Central Council for Nursing Midwifery and Health Visiting (1999) other stakeholders involved in nurse education also have a major influence on its development.

There would appear to be a tension currently amongst the different professional groups around the issue of conflicting demands of fitness for practice (Statutory Bodies), fitness for academic award (University Quality Assurance Mechanisms) and fitness for purpose (NHS Trusts, Service Users and Carers and Educational Consortia).

The review of the literature shows that whilst the ideas around fitness for practice and fitness for award are fairly commonly understood by stakeholders, the notion of fitness for purpose appears to be almost idiosyncratic to the individual with some commonly held perceptions across each stakeholder group which are identified in this study as Service Delivery, Education and Service Users. (See page 47 for group members).

The intention of this study is **not** to provide an evaluation of the current preparatory courses for mental health nursing, as this issue has been the subject of much research already, as shown in the literature review. Rather this study is about the management of stakeholder perceptions of fitness for purpose issues. The primary purpose of the study is to better understand and develop ways of managing the delivery of mental health nurse education taking into account the perceptions of the stakeholders. As an education provider, it is important that any educational activity created and delivered is seen as being useful by those who manage the Health Service. As an education manager, there would be no sense in producing a course, which the target market felt was not fulfilling a major need.

The implications for the study are that if it proves to be true that there is a wide diversity of perceptions around fitness for purpose, this creates a series of research questions which, when answered, show whether there is any way to produce a curriculum for mental health nursing which is able to reconcile the different perceptions, or to find an alternative way in which these differences in perception and expectation can be managed. The study therefore contributes significantly to the practice of educational management directly in the field of nurse education and potentially in the much wider education management field generally. The general management issues are based around how to negotiate and perhaps influence stakeholders and to produce courses that are fit for purpose, practice and award.

The study also makes a significant contribution to the theory of educational management, particularly in the area of advancing the understanding of how the needs of disparate stakeholders may be managed within quality assurance frameworks. With the focus in all public service industry clearly shifting towards customer satisfaction and public accountability, furthering the understanding of how meeting the needs of practitioners can potentially be managed represents a significant contribution.

Chapter 2 - Review of the Literature

The review of the literature concentrates upon contributions that illuminate the understanding of the notion of fitness for purpose. The greater part of the literature reviewed dates from the publication of the Project 2000 report by the United Kingdom Central Council for Nursing Midwifery and Health Visiting (1986). Literature prior to this date has been included where it has a substantial bearing on the focus of the study. As there have been substantial policy changes in the Health Service relating to mental health nursing and education, the impact of those policy changes are also examined in this literature review.

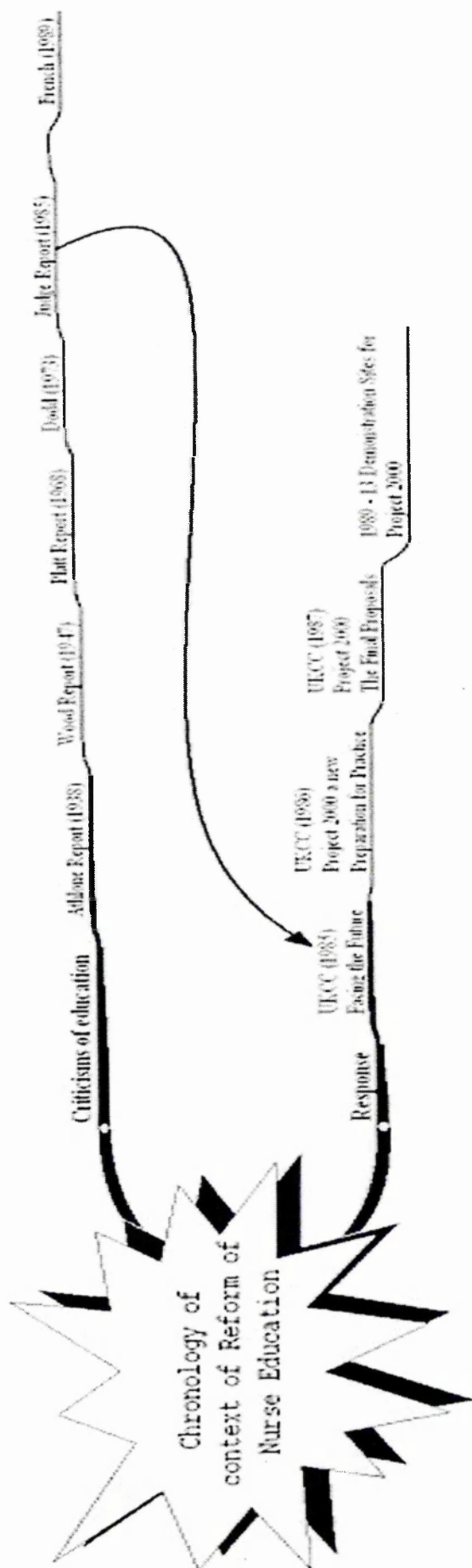
The main ideas and concepts covered in the literature review are focused around how nurse education generally has developed to the position it now occupies, showing the main driving forces behind the developments. The perceptions are then analysed using accounts from published reports and research studies, with the local picture being examined mainly through documentary analysis of meetings held.

Background to Policy Changes

Both nurse education and The National Health Service (NHS) have been the subject of many reports, reviews and reforms. Various government policy and legislative documents have substantially altered how the NHS has been managed and subsequently how nurse education has been delivered. It is worthy of mention that until the Project 2000 reforms took hold and nurse education subsequently moved into the higher education arena, it was considered as being part of the NHS and therefore subject to the same reports and policy influences as the health service.

The background and history of the development of Project 2000 is well summarised in Jowett and Walton (1994), whose research funded by the Department of Health was intended to evaluate the first 13 demonstration districts for Project 2000. They describe the reforms as emerging from sustained widespread debate about the future of nursing and nurse education

which stretches back several decades. They cite several reports (Athlone Report (1938); Judge Report (1985); Platt (1964); and Wood (1947)) which had all criticised nurse education, made specific recommendations, several of which were similar in many ways to those of Project 2000. Jowett and Walton (1994), however, assert that the recommendations of these reports do not appear to have had a significant effect upon policy or practice. The main concerns of all these reports were identified by Jowett (1994) as having to do with educational standards, service delivery, recruitment and retention of students and changes in the NHS and in the health needs of the population. The climate for reform and major changes in policy and practice were therefore, they argue, gathering momentum. There was a growing feeling amongst the Statutory bodies that reform was needed, but that it required a major consultation exercise in order that the views of the profession were taken into account and that the Project 2000 reforms did not suffer the same fate as the reports which were its predecessors. Please see the diagram on the following page of the chronology of the reform of nurse education.



Intentions of the Statutory Bodies

In 1986 the UKCC published a consultation report to gauge the views of the nursing profession about the proposed reforms for nurse education. At the same time the Consultant firm Price Waterhouse was employed to look at the cost/benefit and human resource implications. This would appear to have been fairly shrewd of the UKCC, in that they hoped to establish through the consultation, that the profession was strongly in favour of the proposed reforms.

The UKCC further hoped to establish through the Price Waterhouse cost/benefit analysis, that the proposed reforms represented value for money. A summary of the main intentions of Project 2000 as stated in the report by Price Waterhouse (1987) is as follows:

- There should be a new division of labour – a new single level of registered practitioner would emerge to replace the current first and second level practitioners. The new practitioner was described as a ‘knowledgeable doer’.
- There should be a new pattern of preparation – the existing 3 year training courses in different specialities would be replaced by a course with a common foundation programme of 18 months duration followed by an 18 month specialist branch programme.
- There should be improvement in educational standards – the new programme should have academic standing as an advanced educational qualification with closer links between schools of nursing and academic institutions.

The apparent care taken in the consultation process paid dividends for the UKCC, and Project 2000 became a reality with 13 demonstration districts being launched in England in 1989. The first nurses to qualify with the new type of qualification would have therefore entered the system in 1992, and if the rhetoric of Project 2000 was to become a reality, this new breed of nurse would transform practice.

The UKCC, through their efforts, clearly had an agenda that was based upon a drive to raise the academic and professional level of nursing as a profession. They wanted nurses to be more able to think and act at a higher level than previously and to be adequately prepared for that role.

Policy Changes in Mental Health Nursing

Prior to the Project 2000 reforms, mental health nursing had itself undergone a major change in 1982 with the publication of a new syllabus for training developed by the English National Board for Nursing Midwifery and Health Visiting (1982). This syllabus moved psychiatric nursing away from a medical psychiatry dominated model, to a model that stressed the importance of the interpersonal skills of mental health nurses. There did, at this point appear to be an element of conflict between the ENB and the UKCC, at least in the area of mental health nurse education. The UKCC were looking towards a common foundation programme of 18 months and branch programmes of 18 months, whereas the ENB were looking more towards maintaining the separate 3-year course in mental health nursing.

Mental health nursing had undergone a long history of change that began with the early asylum warders whose primary task was the containment of patients. When the 1959 Mental Health Act came into being, this role then became more concerned with caring for people with mental health problems. Initially this caring mostly consisted of administering medication prescribed by doctors, but steadily from the 1960s onwards, became more concerned with interacting with patients. There is a parallel here with the views of society towards mental health and to the role of medicine and nursing. Prior to 1959 patients with mental health problems were mainly regarded as being dangerous lunatics (presumably whose actions were governed by the phases of the moon) who needed to be kept apart from the general public and locked away somewhere safe. The word 'asylum' typifies this notion of a safe haven.

From the 1960s onwards, there was a growing view that rather than being 'lunatics' these people were suffering from mental illness. People with illness therefore require the services of the medical and nursing professions. In the 1960s, doctors diagnosed and prescribed medical (usually chemical) treatment and nurses administered it and 'looked after' the patients. Steadily through the next four decades, the caring role of nursing generally and the skills of interpersonal communication in mental health nursing in particular became more important.

There was a strong feeling within the mental health nursing field of the ENB that these interpersonal skills were the main tools that mental health nurses possessed and that whilst it was best that they were regarded as nurses, they were substantially different from general nurses and therefore required a separate 3 year educational preparation.

When the Department of Health subsequently reviewed the role and training of mental health nurses in the *Working in Partnership* report by the Department of Health (1994) it was found that there were many generic skills across the range of mental health professionals, but that in the case of mental health nursing, caring, rehabilitation and medication supervision skills were highlighted as being specialist. The concept of caring, however, is open to extremely wide interpretation, and is not given a detailed description or analysis in the report.

The *Working in Partnership* report made 41 recommendations in total about the nature of mental health nursing, including an examination of the appropriateness of Project 2000 for the training of mental health nurses. One major recommendation was that the review believed that the balance of an 18 month Common Foundation Programme (CFP) and an 18 month specialist branch programme (which was one of the fundamental characteristics of Project 2000) was inadequate in terms of the time needed to develop the required skills of the mental health nurse. A move towards a one year CFP and two years specialist branch was suggested. This review coming only six years after the establishment of Project 2000, suggests that, for mental health

nursing, the Project 2000 reforms were not delivering qualified nurses fit for practice or indeed purpose. This seemed to be centred around the view held by the ENB, and mental health nurses generally, that moving away from a three year course in mental health nursing would dilute skills of the profession.

A clue to the nature of the dissatisfaction is found in the conclusion of the review which stated that 'the essential focus for the work of mental health nurses lies in working with people with serious or enduring mental illness and tertiary care regardless of setting'. The current focus of the training was seen as being institutionally based and required, according to the authors of the review (Department of Health 1994), to have a much stronger community basis.

As a response to the *Working in Partnership* review, a research study entitled *The Changing Needs of Mental Health and Learning Disabilities Nurses* was conducted by the English National Board for Nursing Midwifery and Health Visiting (1996). In the study the changing educational needs of mental health and learning disability nurses were categorised into seven themes as follows:

- Working with others - inter-professional, multi-agency and multi-disciplinary team working skills.
- Clinical practice - management and leadership skills, skills of developing self and others
- Learning formats – Interpersonal communication and counselling skills, group-work skills, knowledge of basic anatomy and physiology, particularly in relation to neuro-pharmacology and neuro-psychiatry.
- User enablement and empowerment – recognition of user empowerment and advocacy as fundamental to the relationship between user and nurse.
- Responding to the market and service priorities – skills relevant to the care of people with severe and enduring mental illness.
- Values – user empowerment, confidentiality, open and honest relationships with users and carers based on mutual trust and respect.

- Impact of new models of care – risk assessment and management, assessment skills in dependency and self-harm.

These themes were intended to form the basis of a way forward for looking at core skills in mental health nursing, and whilst they may, on the surface, appear to be useful, they actually give very little specific guidance.

Several problems exist with the themes as they are presented. The presentation of the skills as being for both mental health and learning disability nursing, rather than specifically having a discreet set of skills centred on mental health, tends to dilute the impact of the recommendations as the emphases of the different nursing branches are different. Mental health nursing has a therapeutic emphasis, whilst learning disability nursing has an educational emphasis.

The 'working with others' theme is not specific to mental health nursing but is general to nursing overall. This is also true of all of the other themes with the exception of the learning formats theme, which lists interpersonal communication and counselling skills, group-work skills, knowledge of basic anatomy and physiology, particularly in relation to neuro-pharmacology and neuro-psychiatry. This is a fairly useful list, in terms of identification of knowledge and skills required of mental health nurses, but in the emphasis on anatomy and physiology and pharmacology, there is a hint of a return to the medical model where mental illness is seen as being mainly based in pathophysiology and treatment therefore mainly consists of medication. The rest of the literature in the field does not support this view.

The report entitled *Pulling Together* published by the Sainsbury Centre for Mental Health (1977), is seen as being of high importance to this study, as it directly examines both the perspectives and needs of some of the major stakeholders, looks at the mismatch between training and practice and makes recommendations as to the future skills and competencies required of mental health workers. Central to the recommendations of this report are once again, the establishment of core competencies for mental health workers and the

philosophy of multi-professional groups working together with mental health issues. This raises many issues of shared learning and professional roles and boundaries.

The core skills recommended by the *Pulling Together* report are as follows;

- General training in mental health
- Appropriate values and attitudes
- Appropriate communication skills to develop and maintain effective therapeutic relationships with clients
- Listening and questioning skills
- Written and verbal skills which contribute to inter-agency working
- Flexible approach
- Willingness to learn from others and to apply a problem-solving approach
- Knowledge of the needs of minority groups and black and ethnic minority cultures
- Understanding of the Mental Health Act 1983 and other relevant legislation

The core skills put forward here are intended to be applicable in varying degrees across all disciplines caring for people with mental health problems. The main specific recommendations of the report for mental health nursing are the re-structuring the Common Foundation Programme by shortening it to 12 months, in a similar way to that suggested by the Department of Health, (1994) and prepare mental health nurses to take the lead role in shared care arrangements with primary care and the support of practice nurses who are involved in care of people with severe mental illness.

The *Pulling Together* Report took written evidence of the views of stakeholders, comprehensively reviewed the relevant literature, surveyed the views of mental health care staff, surveyed service users' needs of professionals, analysed mental health workforce trends and analysed the outcomes of all current professional training.

Once again in attempting to look very broadly at the needs of mental health workers, the specific skills required for mental health nurses were not so clearly specified that it could benefit mental health nurse education to a substantial degree. It was slightly disappointing that given the resources of the Sainsbury Centre and the robust structure of the research conducted, that the results were not specific enough to be of direct use to curriculum planners and commissioners of education.

In reviewing the literature on interpersonal skills in mental health nurse education Mills (1996) examines the relationship between core mental health nursing skills and therapist qualities. He argues that there is no general theory of psychiatric nursing which enables students to predict the interpersonal behaviours most appropriate in the diverse range of situations in which they find themselves. This is consistent with many of the evaluative studies of mental health nursing skills for example the work of Barker (1989), Reynolds (1990) and May (1990). The common view amongst these writers seems to be that there is a set of interpersonal skills and behaviours which are valued by patients and clients, but that they are extremely diverse, difficult to quantify and therefore their inclusion in a curriculum is fairly problematic.

In a review of the psychiatric/mental health nursing literature 1982-1992, Yonge *et al* (1997) argue that although there is a drive towards research based practice in nursing, the scientific merit of the research is variable. In addition Yonge's findings suggested that a large part of the research was being conducted without adequate funding, and that some of it was of questionable quality.

According to Secker (1998), mental health policy needs to concentrate upon models of positive mental health promotion rather than looking at illness models. This is entirely consistent with the philosophy of Project 2000 as stated by, the United Kingdom Central Council for Nursing Midwifery and Health Visiting (1986), which was entirely based around the concept of health rather than illness.

According to Jones (1999), mental health policy... (from 1999)

'is about to embark on a 10 year strategy of modernisation.'

The modernisation agenda is intended to include better equipped 24 hour emergency crisis teams, selected targeting and increased provision for acute and secure beds to manage those with severe and enduring mental health problems. In addition to this, there promises to be much improved resources for community care according to the report entitled *Modernising Health and Social Services* by the Department of Health (1998)

According to Nolan *et al* (1999), another driving force in the changing world of mental health nursing is the apparent increase in violence against mental health service personnel, and training in the management of violent and potentially violent incidents is advocated, as is support for staff.

This theme is also developed in a study looking at managed mental health care by Jones and Norman (1998) in which it is argued that the core skills of the mental health nurse are unlikely to change, but that there is a need to move towards a clearer definition of outcomes of care and the use of research based interventions and rating scales to measure the outcomes. In a later piece of research, and with the impact of the government's health service modernization agenda in mind, Jones (1999) argues that whilst care pathways may be a way forward, there are problems and difficulties in attempting to formulate standardised protocols for treatment as this conflicts with the principles of individualised care.

The Standing Nursing and Midwifery Advisory Committee Department of Health (1999a) followed up on these ideas by strongly recommending that more and better training in the skills of mental health nursing needs to be provided. The report continues by mentioning specific areas of skills deficits in the areas of risk assessment and management, observation, de-escalation processes and control and restraint techniques, which the report argues save lives. The report, however, advocates post-registration courses in these areas and does not advocate them as part of the initial education.

The literature in this area seems to be in general agreement that there should be a core set of skills for the psychiatric nurse. The contentious points are what those skills might be, the arguments ranging through a simple set of qualities as advocated by Carl Rogers - i.e. genuineness, warmth and empathy (Rogers 1957) - through to the work on key skills done by the ENB and the Sainsbury Centre. (Ibid. 1996)

Rogers and Pilgrim (1994) studied the specific skills of psychiatric nurses that were valued, from the perspective of the service users and carers. This study found that the kinds of nursing interaction that were found to be the most useful were interactions like listening, engaging in ordinary, everyday conversation. Counselling and empathy were also mentioned, but the precise meanings of those terms as described by service users were unclear.

In a similar small-scale study, Beech and Norman (1995) found that the clients valued the simple interactive skills of the nurses in spending time with the clients, listening to them and providing helpful explanations of their care. The clients saw these activities as showing respect for them as people.

Lovell (1995) conducted a service user satisfaction study on three acute admission wards in a London hospital. The findings of this study appear more as service user *dissatisfaction* rather than a satisfaction study. Rather than highlighting the skills and qualities valued, it tends to concentrate more on what was absent or what was done by mental health nurses that was not valued by clients. The main concerns expressed by service users clustered

around the issues of the treatment being offered to them as being very medically focused. This left them almost completely excluded from the decision making process around their treatment. This resulted in a perception of poor admission processes, poor quality of information about their illness, treatment, medication, prognosis or progress. A recurring theme in this study was a perception that there appeared to be very little time where clients and nurses interacted.

Thomas and Bond (1996), conducted a literature review on client satisfaction with nursing care which emphasised the notions that positive interpersonal relationships with nurses, rapport and support were regarded by clients as indicators of high quality of care.

Several studies, notably by Barnes and Sharlow (1997) and Repper (2000) have found that the notion of partnership in care is a vital component of the perception by clients that they are receiving high quality of care. In the study carried out by Walker and Dewar (2001), the notion of partnership in care, which included the clients' relatives and carers as well as the client, was seen as an indicator of high quality care. In a wide consultation study conducted by Rose (2001), it was noted that users and carers were expressing a concern over perceived lack of participation in care planning, over-reliance on medication as the main method of treatment and poor interactions with nurses.

It would appear from the literature therefore, that users and carers perceive that they are receiving high quality of care when nurses spend time with them: listening, engaging in ordinary, everyday conversation, showing empathy and demonstrating simple interactive skills. These simple interactive skills include listening to them, showing respect for them as human beings and providing helpful explanations of their care.

Care was perceived to be of low quality when the treatment being offered was very medically focused. This left them feeling almost completely excluded from the decision making process around their treatment. Poor care was also characterised by a perception of poor admission processes, poor quality of

information about their illness, treatment, medication, prognosis or progress. Most importantly, poor care was characterised by nurses appearing to have very little time or skill in interacting with clients, which resulted in a lack of participation in care planning and an over-reliance on medication as the main method of treatment.

From the perception of users and carers, the constituent parts of high quality care, appears to be very clear both when it is evident and when it is absent.

Policy Changes in Nurse education

The literature relating to the qualities of a good nurse, from Florence Nightingale's ideas of 'restraint, discipline and obedience', through to the current fitness for purpose debate, are well recounted in Macleod-Clark *et al* (1997b) the authors regard the move towards academic status for nursing, and the subsequent movement of nurse education into universities, as particularly important. Perhaps the most important change is seen as the shift away from an illness-based to a health-based model of nursing. Macleod-Clark's study argues that the 'different type of nurse' as described in studies of traditionally trained nurses by Melia (1987) and Henderson (1966) is beginning to emerge. The different type of nurse referred to here is variously described as the knowledgeable doer - a nurse who not only knows how to carry out nursing, but also is able to understand the theory and the wider implications of what they are doing. This again, was one of the main driving forces behind the initial introduction of the Project 2000 initiative.

Further review of the primary drivers of the need for change in nurse education can be found in the work of Bentley (1996), who identifies the main ones as changes in the Health Service and the move to professionalise nursing. This compares with the work of Briggs (1972), Platt (1964) and Wood (1947), all of whom identified these issues as major drivers.

Since the introduction of Project 2000, there have been growing concerns amongst practitioners that theory has been viewed by nurse educationalists as more important than practice as reported in the work of Macleod-Clark *et*

al (1997a) and Carlisle *et al* (1999). Furthermore, according to Stanton (1994) there has been an increase in the amount of classroom-based learning carried out within nurse education. Stanton argues that because of the increase in the amount of classroom teaching delivered, there has been an increase in its perceived value by nurse educationalists.

Some writers, for example Clark (1991) and White (1995), have questioned the need at all for a Common Foundation Programme (CFP) for mental health nurses. The reason for questioning the need for a CFP may be, in part, due to a desire to maintain the three-year, full time dedicated mental health nurse training which was in existence prior to Project 2000, and a reflection of resistance to change. Alternatively, it may be more connected with a real concern which is also reflected in the *Pulling Together* report by The Sainsbury Centre for Mental Health (1997) that 18 months of specialist training is not sufficient to develop the skills necessary for mental health nurses to be fit for purpose.

According to Ben-Zur *et al* (1999), the literature documents an increasing number of attempts to develop educational programmes that will fit future changes in the health service. This points to nurse education as being a fairly reactive entity that is apparently attempting to meet constantly changing and shifting needs instead of being proactive in designing innovative programmes.

Match of needs and provision

Views of Students

Parker and Carlisle (1998) found that students had an overall positive view of their course in that they appreciated the value, relevance and breadth of their training, but felt that the programme lacked coherence and organisation and at times were dissatisfied with teaching methods utilised.

According to Ferguson and Hope (1999), who studied graduate mental health nurses at different stages in their educational preparation, the students at the end of their programme felt that they had been well prepared for their role as qualified nurses. This had not been the case when the students had been

interviewed at the end of their common foundation programme. The study, however, acknowledged the difficulty of separating out the maturity factor in this phenomenon.

Views of Other Stakeholders

Following the implementation of Project 2000, several attempts have been made to evaluate its effectiveness in different areas. Kirk *et al* (1997), looked at the implications of the formation of links between higher education and the National Health Service, and made the point that as higher education establishments demand more academic credibility, teachers' clinical development may well suffer. Nurse teachers had previously spent substantial amounts of time in clinical practice in an effort to retain clinical credibility. Higher education establishments were now seeing this time as being a questionable drain on resources, and that the time might be better spent gaining academic credibility. This appears to support the notion that the concerns of the universities are mainly based around fitness for award, rather than fitness for practice or purpose.

The English National Board for Nursing, Midwifery and Health Visiting funded an evaluation study of Project 2000, which produced findings that showed the students describing themselves as 'knowledgeable doers'. This meant that they saw their practice as grounded in theory, that they were utilising evidence based practice and that health service managers would be keen to employ them once qualified. This was published as an article entitled 'Project 2000: perceptions of the philosophy and practice of nursing' by Macleod-Clark *et al* (1997a). There was, however, an acknowledgement by the managers in that study, that the students required a period of supervised practice after qualification (preceptorship). The implication here being that by the end of the three year basic course leading to registration, although the students were by definition fit for practice, they were not yet fit for purpose.

Central Government Policy for Mental Health

In order to further clarify the policy issues in *Modernising Mental Health Services* published by the Department of Health (1998), the Government

published a National Service Framework for Mental Health once again under the auspices of the Department of Health (1999b). This document is extremely comprehensive, and not only spells out in detail, policies and standards for mental health, but also clearly specifies how it is intended that this should be achieved.

The National Service Framework for Mental Health (Department of Health 1999b) (NSFMH) was one of the first of a series of such frameworks to be published. The stated intention for the publication is to cover the most significant causes of ill health and disability in England; for example, coronary heart disease and mental health were the first two frameworks to be published. Several more national service frameworks covering other areas such as care of the elderly and care of children were subsequently published adopting similar formats. It is interesting, that the NSFMH covers only the mental health needs of working age adults up to 65. There clearly is an agenda here, to address the needs of the working age population as a priority.

The two initial priorities of coronary heart disease and mental health were identified as priorities in *Modernising Health and Social Services* by the Department of Health (1998).

The NSFMH itself was published both as an executive summary (32 pages) and the full report, which was some 150 pages long. Both documents were made available free of charge on the Internet via the Department of Health website. (Department of Health, 2003a, 2003b).

The foreword written by the Secretary of State sets the scene for the framework by stating that although mental illness is prevalent and important, it carries a stigma. The framework seeks to set out national standards, show how these should be delivered and how performance should be measured. The foreword ends by stating that the Government is committed to do whatever is necessary to deliver on the framework and that '*... this National Service Framework will set the standards and these standards will be met.*'

The foreword immediately gives an impression of central control. Standards would be set at a national level, performance would be monitored against these standards and this process, in turn, would serve as a guide to future investment.

Using a process of reading and re-reading the document, and asking the question of what is being said, what is behind the words printed in the document, the words and ideas most obviously reiterated, in order of priority, (measured by how often they appear and how much space is devoted to the ideas) include the following:

1. Central Control /Record keeping
2. Look after the working age population
3. Involvement of service users and carers
4. Partnerships in care/ Multi-professional working
5. Wide variety of services to meet diverse needs
6. Reduce Stigma of mental illness
7. Look after vulnerable people
8. Right to assessment and access to services
9. High quality care
10. Non discriminatory
11. Staff Training is essential

12. Suicide prevention

With the publication of the National Service Framework by the Department of Health (1999b) the West Yorkshire Education and Training Consortium (2000) commissioned a project to manage the development of an education and training framework and commissioning strategy for mental health nurse education. The project had the following aims:

- Develop networks across West Yorkshire and Northern and Yorkshire Region
- Review existing training provision in mental health
- Develop an education and training framework for mental health in West Yorkshire
- Identify skills and competency gaps
- Make recommendations for a commissioning strategy for mental health in West Yorkshire

The project's findings were interesting, and pointed towards the general trend in mental health to strengthen multi-disciplinary multi-agency working, the promotion of user and carer involvement and a promotion within the general population of a broader understanding of mental health.

In structural terms, the report recommended the establishment of a consortium-led network of mental health training councils and the establishment of a mental health advisor role.

The authors of the project admitted that, although they were aware of the importance of the involvement of users and carers, their educational needs were poorly represented in the data collected for the project.

The method of selecting subjects for participation in focus groups and interviews appeared to adopt a cascade approach in that key individuals were identified as contributors from various stakeholder groups, who then recommended other potential contributors who could be approached. This could well have introduced a significant element of bias into the study. The researchers selected the initial 'key individuals', and these 'key individuals' then selected each subsequent contributor; this may have resulted in only those with a particular set of views being selected as subjects. The potential bias that this might have introduced was not acknowledged in the report.

The findings and recommendations were very close to the 'party line' as espoused in the National Service Framework. It was also difficult, at times, to trace back how recommendations related to findings.

A model was formed covering the following three themes, which neatly fitted in to the standards of the National Service Framework

- **Working with professionals and teams, including:**
 - Team Working, negotiation
 - Preceptorship mentorship
 - Creating opportunities for change
- **Working with service users and their carers, including:**
 - Legislation, human rights, compassion

- Relationship and care skills
- Understanding of common mental disorders
- **Working within the service at this time, including:**
 - Political awareness
 - Specialist services, reaching out to socially excluded groups
 - Challenging low expectations – users, carers, staff and services
- stigma

These three themes are described as ‘fundamental pillars’ of mental health care working and development. A fourth theme was introduced which introduced the notion of a mental health–illness continuum. This spectrum of mental health is described as covering primary care to tertiary care and beyond into the criminal justice system. The report specifies that a framework for mental health training activity can and should be overlaid against this mental health-illness continuum. In other words all education for mental health nurses should take into account that the mental health needs of the population are wide and varied, from the person with mild stress related problems, to the person with severe and enduring mental illness.

A further research project was funded by the West Yorkshire Training and Education Consortium (later to become the West Yorkshire NHS Workforce Development Confederation), which examined in detail, the client, carer and student experience of interpersonal skills and therapeutic intervention. This project conducted by Mills (2002) collected empirical data through consultation with clients, carers, clinical staff and student nurses and gives (in my opinion) a clear and up to date evaluation of the local context

particularly in the area of the types of interventions which are considered by clients, carers and students as being of high value.

A further project was carried out by The Sainsbury Centre for Mental Health (2000) with the overall aim stated as being;

‘to identify a broad unifying framework which encompassed the set of skills, knowledge and attitudes required within the workforce of mental health practitioners to effectively implement the National Service Framework for Mental Health.

THE REPORT DESCRIBES CAPABILITY AS INCLUDING SEVERAL KEY COMPONENTS

- Performance component – including the skills that people need to possess and what they need to achieve.
- Ethical component – integration of a knowledge of culture, values and social awareness into practice
- Reflection – an emphasis on reflective practice in action
- Implementation of evidence based interventions – the ability to utilise research findings to enhance practice
- Working within new models of professional education and responsibility for lifelong learning.

The framework divided capability into 5 areas

- Ethical Practice
- Knowledge of Mental Health and Mental Health Services
- The Process of Care
- Interventions

- Applications to specific service settings

A detailed list of capabilities was then included for each of these areas, and cross referenced to the National Service Framework for Mental Health, thus forming the basis of the framework.

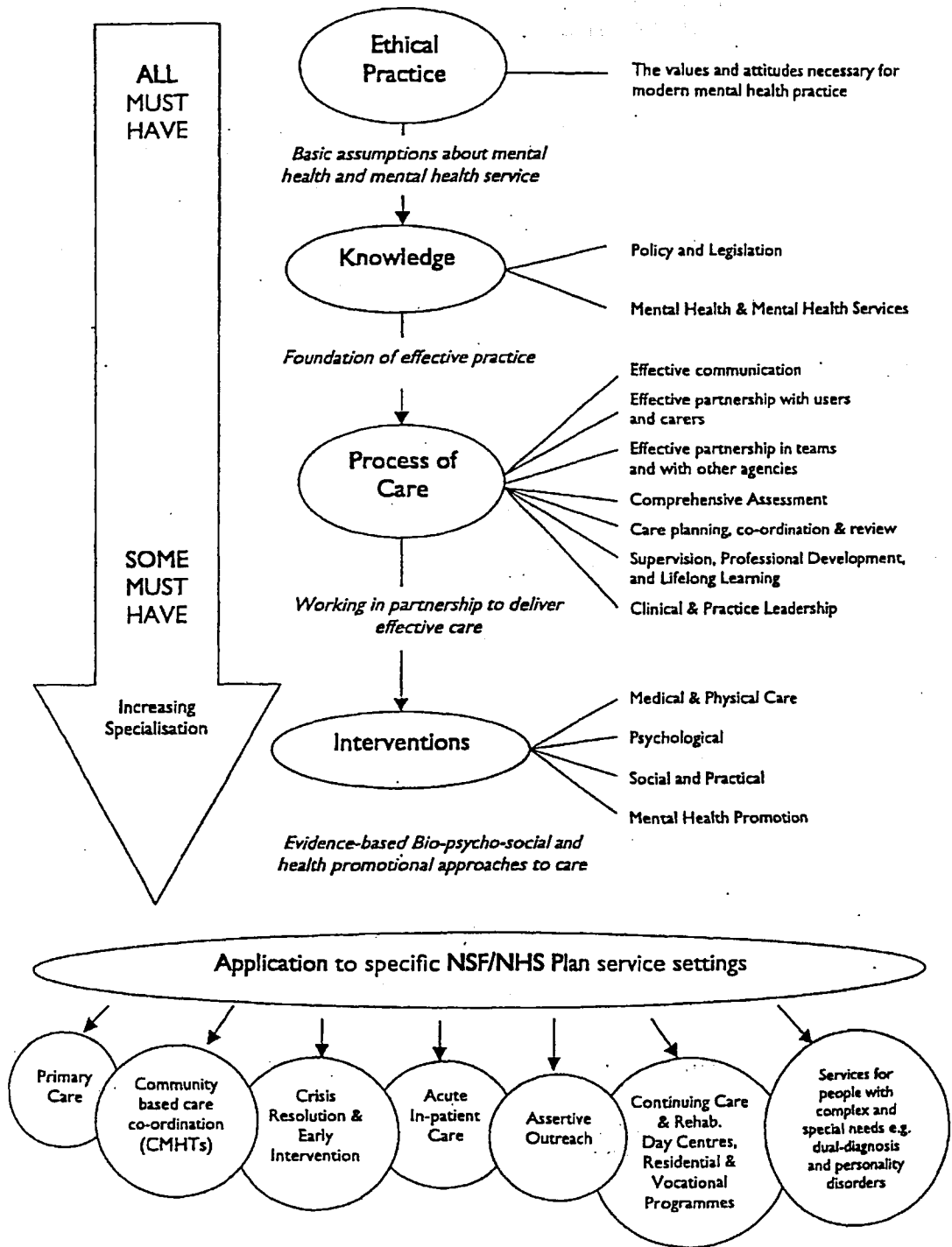
Several possible applications were suggested for the capability framework, one of which was to give education providers a framework for generating post National Service Framework curricula. The framework devised was very detailed and incorporated a sliding scale of capabilities, which are needed by all practitioners in mental health through to those that are needed by some specialist practitioners.

The methodology of the research that led to the report is described as a complex methodology, weaving together several strands of enquiry. The methodology is described as concept mapping to elicit the views of service users, carers and mental health professionals. A set of key tasks (tasks undertaken by mental health workers which were viewed as being valued by stakeholders) was then developed by an expert panel from the concept maps. These key tasks were then utilised to conduct a national survey tool, which was completed by a representative sample of staff working in community and acute in-patient settings to gauge their relative importance.

The final stages of analysis are described as code and match analysis, which consisted of mapping the tasks into a range of competencies within specific domains.

A diagrammatic view of the framework from the Capable Practitioner report by The Sainsbury Centre for Mental Health (2000) follows;

A Framework for Capable Practice



As can be seen from the framework, recommendations are made as to what is needed in terms of knowledge, skills, values and attitudes, in order to deliver a high quality mental health service within the current policy agenda.

The Sainsbury Centre for Mental Health (SCMH) utilises its links with Kings College in London in the conducting of its research projects, and although the published reports tend to be fairly scanty on the actual detail of the range of methodologies utilised, the quality of the research does appear very high, having utilised Kings College's resources and expertise. Furthermore, Government does appear to take heed of the output of the SCMH, as evidenced by the similarities in recommendations between the Sainsbury Centre's work and the National Service Framework for Mental Health. It is worthy of note that although the research undertaken to produce *The Capable Practitioner* was conducted prior to the publication of the National Service Framework for Mental Health (NSFMH), the capability framework has been very successfully cross-referenced to the NSFMH.

A report which is of particular importance to the study is a report published by the United Kingdom Central Council for Nursing and Midwifery entitled *Fitness for Practice* published by the United Kingdom Central Council for Nursing Midwifery and Health Visiting (1999) This looks at the education of nurses and midwives in the light of evaluations of Project 2000 to date, and makes recommendations for the future. A summary of the concepts of fitness of that report is as follows;

Fitness for Practice

The notion of fitness for practice would appear to be based around the endorsement by the professional bodies that an individual has met, and is continuing to meet nationally laid down standards by the United Kingdom Central Council for Nursing Midwifery and Health Visiting (1999)

Fitness for Purpose

According to the United Kingdom Central Council for Nursing Midwifery and Health Visiting (1999), this is about whether the individual nurse is able to function competently in practice. They continue by stating that this is a difficult concept to define as the meaning cannot be fixed due to the pace of change.

Fitness for Award

Again the UKCC do not see this as their domain, but rather that of the universities. They state that fitness for award does not mean fitness for purpose, but that most employers acknowledge academic awards as markers of achievement.

The *Fitness for Practice* report has sparked a whole new round of bidding processes for Universities vying to be one of the first demonstration sites for the new 'Fit for Practice' type of training. This is reminiscent of the 'gold rush' which happened amongst schools of nursing in the late 1980's to be amongst the first to implement the Project 2000 course.

Whilst the *Fitness for Practice* report has undoubtedly taken into account most of the published literature in the field of how satisfied students are with their course, and how managers and potential employers of newly qualified students, other stakeholders' views have not been looked at in any great detail. Very little mention is made of users, carers and advocates, or the responsibility of the nursing profession to the general public.

Furthermore, although the report makes reasonably clear recommendations as to what should be achieved by those creating curricula, there is no advice offered as to how the delicate balance of managing disparate stakeholders perceptions of what is expected of newly qualified nurses. Indeed the report merely writes off the notion of fitness for purpose by claiming that 'it would be unreasonable to expect that fitness for purpose could be a function of pre-registration nurse education'.

Whilst it would be entirely strange to imagine that the function of pre-registration nursing was without purpose, the notion expressed in the report that 'the meaning (of fitness for purpose) cannot be fixed due to the pace of change,' gives the impression that due to the difficulties in defining or understanding the concept, it has been defined as being outside the scope of the report. This is a surprising conclusion in that if it is unreasonable to expect that fitness for purpose is a function of pre-registration nurse education, then the UKCC appear to be implying that newly qualified nurses are not fit for purpose at the point of qualification.

In an attempt to resolve the conflicting demands of stakeholders in the areas of fitness, the UKCC continue by suggesting that pre-registration nurse education should re-focus on outcome-based competency principles, although the reasoning behind this is omitted and may say simply something about the ideology of the authors of the report as being advocates of competency based education. They continue by suggesting that the different stakeholders in nurse education should agree a set of learning outcomes to cover the knowledge, understanding, skills, abilities and values expected of newly qualified nurses, which fits with the work of Storey *et al* (1995) entitled *Utilising Occupational Standards as a complement to nursing curricula*. This work once again raises, but fails to throw any light upon the question as to how the integration of Occupational Standards into nursing curricula can be managed, but simply advocates that it should be so.

Summary

The literature shows that whilst the ideas around fitness for practice and fitness for award are fairly commonly understood by stakeholders, the notion of fitness for purpose is almost idiosyncratic to the individual with some commonly held perceptions across each stakeholder group. The issues are therefore focused around how these widely conflicting perceptions can be understood and managed to find if there is a way to reconcile the different perceptions, or to find a way in which the differences can be managed.

The research, therefore, assesses the perceptions of the major stakeholders of the course i.e. students, teachers, clinical supervisors, NHS trust managers, education consortium members, qualified nurses, mental health service user and carer groups and purchasers of health care (health authorities). It is also recognised that the general public is a major stakeholder in health care, and in order to establish the perception of this group, it was intended to utilise the knowledge and expertise of the Community Health Council in their role as advocates of the general public. I hoped that the findings of the research would assist in management of the delivery of nurse education by finding ways to manage the perceptions of what the education should deliver.

My research questions covered five main areas:

Students' views - What do the students believe their knowledge and skill base should be at the end of the course? Which knowledge and skills do they believe they are deficient in, and what areas included in the course appear to serve no useful purpose? It is important to note that the students' frame of reference of the course may well be very different from my own views, or from all other subjects interviewed. This is, however seen as a strength in the provision of a 'thick description.'

Other Stakeholders views - What do all the other stakeholders believe the knowledge and skill base of student mental health nurses should be at the end of the course? Which knowledge and skills do they believe the students to be

deficient in, and what areas included in the course appear to them to serve no useful purpose?

Political Perspective - What are the needs of the Health Service today in relation to mental health nursing and to what extent does the current provision of nurse education meet those needs?

Fitness - How are the concepts of fitness for purpose, practice and award understood and to what extent are they understood differently by the different stakeholders?

Management of Fitness - Are the perceptions of all the stakeholders similar and therefore able to be reconciled, or are they so dissimilar that it would be virtually impossible to create a provision which meets all the identified needs?

Chapter 3 - Methodology

Bearing in mind the substantial changes that have occurred in NHS policy, in higher education, nurse education and in mental health, the research is concerned with discovering the extent to which major stakeholders perceive that the current provision of education for mental health nurses prior to registration is appropriate to the needs of the NHS. It is recognised that this is a broad focus and therefore requires a variety of types and sources of data and methods. An overview of the types and sources can be found in the following table.

Topic	Data	Methods
Background		
Policy intentions of the Statutory Bodies	Description of ideas and assumptions leading to the development.	Literature Review
National policy context of the introduction of Project 2000	Responses of the nursing profession to the introduction	Literature Review
Policy development in Mental Health Nursing	Changing emphasis of caring for people with mental health problems	Literature Review
Local context of the introduction	Description of introduction in case studied	Curriculum documents and records of meetings. Semi-structured interviews

Topic	Data	Methods
Circumstances surrounding the integration with higher education	Description of Process	Literature Review
Local context of the integration	Assessment of impact locally	Semi-structured interviews with stakeholders
Evaluation		
National context	Extent of satisfaction with the new course	Literature Review
Local context	Extent of satisfaction at a local level	Student and teacher evaluations of course. Meeting records, semi-structured interviews
Ideas for future plans	Exploration of areas of satisfaction and Suggestions for improvement in areas of dissatisfaction	Student and teacher evaluations of course. Meeting records, semi-structured interviews.

Because my main concern was to get at perceptions I designed a method of interviewing which was adapted from therapeutic techniques with which I was familiar. I felt that there were similarities between what I might do in a therapeutic interaction with a client which enabled me to facilitate the clients to share with me how they perceived their world and their problems, and the notion of finding out what stakeholder perceptions were.

Framework for the study

As the data gathered for the study relates to the subjective experience, perceptions and opinions of stakeholders, a framework capable of an in-depth analysis of these issues was required.

Hill Bailey (1997) cites Guba (1990) who argues that any process of formal inquiry is guided by a set of 'basic beliefs' which form the paradigm of the research. The basic beliefs are built around the three questions of what the nature of knowledge is (ontology), what the relationship is between the researcher and the knowledge (epistemology) and how the inquirer finds out about the knowledge. (methodology)

Ontology

The data gathered for this study is based around the belief that reality exists only in relation to the lived experience of the subjects, particularly as the notion of fitness for purpose is described in many different ways both in the literature and by each of the subjects interviewed. It is argued that in this case there can therefore be no absolute reality which can be objectively measured, it is therefore regarded as being relative to the individual subjects concerned.

This, however, creates a major problem for educational management, in that Stakeholders are inevitably driven by their perspective of what constitutes fitness for purpose and will, in all probability, judge the output of the course against that perception. Judged in this way, the success of a course is likely to be viewed by stakeholders as being directly related to how closely these expectations are met. This study, therefore, examines those perceptions, perspectives and expectations of individuals, with the intention of clearly describing and then finding new ways to manage those perceptions. The management task is concerned with establishing stakeholder perceptions and producing educational programmes which meet the perceived needs and expectations of the stakeholders.

The study is based around the notion that a relationship between the subjects and the interviewer will develop, and that both parties will influence one another to a greater or lesser extent. A further notion adopted in the study is that as the data has been gathered in a top-down manner, firstly from policy makers and then from other different stakeholders who will in some way implement those policies, data gathered from early interviews will influence subsequent interviews. This has been taken into account in the discussion of the findings and in any claims made for generalisability.

Methodology

Given the ontological and epistemological position, the methodology chosen for the study falls within the qualitative paradigm. As the lived experience of the subjects is being studied, described and analysed using the language of the subjects, a particular form of the phenomenological approach has been adopted. According to Cronin (2001), Nursing and hermeneutic phenomenology share the beliefs that people are whole and that they create their own particular meanings. Using this method, the researcher is interested in people's lived subjective experiences in their worlds. The ideas to be explored in this study are concerned with providing a faithful representation of the phenomena experienced by the subjects. The data has been gathered using semi-structured interviews in individual settings, this has facilitated the subjects ability to fully and freely express their thoughts and feelings in relation to their perspectives.

Research Strategy

The research strategy has been to adopt a case study approach for the collection of the empirical data, as the type of data required for this study is data which is entirely consistent with that which is given as a description of qualitative case study. Stake (1995) asserts that in qualitative case study we seek greater understanding of a case. In this type of study, the uniqueness and complexity of the case is explored in its embeddedness and interaction with

its contexts. He suggests that the issues would form the conceptual structure and the initial research questions in order to focus attention on the complexity and context of the case, rather than concentrating on being exclusively descriptive. Stake, however, also stresses the importance of topical information questions, which form the basis of the description of the case. The emphasis of this study, therefore, is not intended to be to explain why things are as they are, but to produce an analytical account of how things are at a particular place and time.

Case Studied

The case chosen for the study has been students taking the mental health branch of the diploma of higher education (nursing studies) course. For the purposes of the case study, for reasons of preserving the anonymity of the interview subjects the institution will be known as Northland. The case studied has been chosen for several reasons. As the University of Northland, currently employ the author, access to documents and people from that area did not prove to be difficult. With the agreement and support already obtained of the local training and education consortium for the study, and their interest in the findings, this further assisted access to people and information.

Further advantages of selecting this case are that it can be claimed on one hand to be fairly typical, and on the other hand, an example of good practice. The course chosen is typical of all Project 2000 courses in that the curriculum is derived from a national outline syllabus. To ensure quality and the meeting of national standards, the English National Board con-jointly validates all Project 2000 courses for Nursing, Midwifery and Health Visiting (ENB) in conjunction with a higher education institution.

The course could also be seen as an example of good practice due to its maturity, and therefore being potentially able to take account of the National Foundation for Educational Research (Jowett and Walton (1994)). One example of this is that in the design of the course in the case studied, contact with practice placements happens very early in the course. This was introduced as

a direct response to early findings that there was a high attrition rate in the pilot courses, which was attributed to students not having sufficient early contact with patients and clients.

One further reason which makes the case interesting to study, but was not a factor in its choice (as it happened after the selection was made) is that the University of Northland has been successful in its bid to become a demonstration site to deliver one of the initial 'fitness for practice' new type of training as per the report of the United Kingdom Central Council for Nursing Midwifery and Health Visiting (1999). The findings will therefore prove to be of interest to other institutions undertaking nurse education and will greatly assist in the management of the external relations with stakeholders.

The original intention of the study was to conduct interviews to discover perceptions about two stages of the course i.e. the end of the Common Foundation Programme (CFP) and at the completion of the course. The reason for these points being chosen was to give a time-frame focus to the interviewees, which all should be able to clearly relate to. The description should then be chronological and diachronic, which should assist in the readability of the study. The end of the CFP is also significant in academic terms, as it is currently when the student progresses from certificate level to diploma level studies. When the empirical data was collected for the study, however, it became apparent that none of those interviewed shared the view that the end of the CFP was significant. All were very keen to discuss the fitness for purpose issues upon completion of the course, but were of the opinion that the fitness for purpose did not occur until the end of the course and the subsequent registration. The interviews, however, did not show that the end of the CFP was a significant point in time. Service provider stakeholder groups did not see it as of particular relevance and had given little thought to the knowledge, skills and attributes required at this stage, they were primarily interested only in the knowledge, skills and attributes acquired by students upon completion of the course.

Interview Sample

The sample for interviews was arrived at by firstly subdividing stakeholders into different groups corresponding to their primary interest in mental health nursing, service delivery, service user, and education provider. A top down approach (beginning with policy makers and commissioners of education through to service deliverers) was decided upon for the interview schedule, in order that the data collection could be informed by the policy framework.

The numbers of subjects chosen from each of the stakeholder groups was to a certain extent opportunistic, but was intended to draw from as broad a range of views as possible

Stakeholder Group		No interviewed
Service Delivery	Department of health	1
	Education Consortium	1
	Health Authority	1
	NHS Trust managers	3
	Qualified Nurses	6
Education	Education Managers	2
	Students	6
	Teachers	5
Service Users	User and Carer Groups	5

It was felt that this schedule would facilitate the broadest range of stakeholder views and take account of stakeholders from all of the major groups with differing primary interests in mental health. The total of interviews decided upon was 30. This I felt was manageable within the time constraints of the project deadlines but still provided a breadth and depth of data.

All interview subjects were offered the opportunity to review and to comment upon the transcripts of the interviews once complete in order to validate the

transcripts. No changes were requested to any of the transcripts, but several subjects did raise a concern that all efforts would be made to protect their identities. Reassurance was given that this would be the case.

Issues local to the case studied

In studying minutes of meetings of local planning teams for the development of the course and its subsequent delivery, it was noted that the constitution of the planning teams include representatives from university with student representation, service delivery and user groups. This wide representation would initially appear to ensure that the needs of stakeholders are taken into account in the construction, delivery and management of the programme. Upon closer scrutiny of the minutes of the meetings, it can, however, be seen that the relative contributions from members other than university members, are extremely limited in their nature.

In studying the confidential minutes of the contract monitoring meetings between the university and the educational consortium, it can be seen that these meetings are held quarterly, and are very formal in structure and organisation. In addition, there are annual contract review meetings. The most senior personnel from the university responsible for the delivery of the various programmes attend these meetings, and there is a slot on the agenda for discussion of issues from each programme.

The meetings are structured around input, process and output issues and how the quality of the programmes is assured. From the notes of the meetings it would appear that, although the meetings are very formal, the relationship between the university and the consortium seems to be very healthy and trusting towards one another. Due to reasons of confidentiality, specific examples of content from those minutes cannot be reproduced in this study.

Issues around fitness for purpose do not, however, explicitly appear to be discussed in any great detail at these meetings, but rather seem to be implicit in the quality assurance mechanisms. The overall impression from the

minutes of the meetings is that the university is trusted by the consortium to deliver high quality education and to report back that they have done so. The consortium is trusted by the university to make known the requirements of the local NHS Trusts and to deal fairly with the issuing and monitoring of contracts.

The consortium funded a series of joint research projects between the university and the local trusts, with the stated intention of facilitating joint research between the two parties that would increase the quality of care through research and education. One such project was conducted specifically with the aims of improving both the levels of interpersonal skills of student nurses and collaboration between nurses and users and carers. This study carried out by Mills (2002) utilised focus groups with different local stakeholders, mainly student nurses, users and carers and qualified nurses to establish what interventions were valued. One major output of this process would be to construct a module, which addressed the needs expressed by the stakeholders during the consultation.

The major findings of the study concluded that mental health nurses are equipped with the knowledge and skill to facilitate interpersonal care, and correctly identified qualities that are highly valued by users and carers. This would appear to indicate both that nurses are aware of, and possess (to a certain degree) those skills and qualities needed in order to deliver care that is perceived by the users and carers as high quality. The study also found that the nurses, both student nurses and qualified nurses, were aware of their need to develop further those skills and qualities.

The key data sought for the case study was that which provided a thick description of the views and perceptions of the major stakeholders in terms of fitness for purpose, practice and award within the current provision of mental health nurse education. Given the subjective nature of these views and perceptions, the major method of collection of data was by the use of qualitative interviews, carried out on an individual basis. Group interviews, were originally planned also, but were rejected on the basis that in order to understand the world of the individual, the subjects required to be interviewed as individuals without the dynamics involved in also being members of

a peer group of some kind. As shown in the findings, this proved to be an extremely useful decision, as individuals felt able to share with me as a researcher crucial information that they would not have felt able to share in a group.

According to Rubin and Rubin (1995) qualitative interviewing is described as a way of finding out what others feel and think about their worlds, how they understand experiences and reconstruct events in which the researcher did not participate. They continue by asserting that how we interview depends, in part on what we are trying to hear. The interviewer/respondent relationship is described as a partnership or collaboration, implying trust and the establishment of rapport. The strategy they recommend for questioning, however, advocates three types of questions: main questions, probes and follow-ups.

Whilst Rubin and Rubin set out a fairly useful way of structuring questions, little help is offered as to how to ensure that the follow-ups and probes are really following up and probing, or whether they are leading and intruding.

Other writers, Cohen and Manion (1994) for example, assert that in order for the interviewer to do the job well - i.e. establish rapport, ask questions in an acceptable manner, and being sincere and well motivated - accurate data may be obtained. The establishment of rapport and the development of the relationship are here again being stressed. Very little help however is given as to how to ask questions in an acceptable manner.

The following two contrasting metaphors for qualitative research interviews, that of the miner and the traveler, are a useful way of looking at interviews. Kvale (1996) firstly talks about the miner metaphor, which looks at the researcher trying to unearth valuable, deeply buried material, whilst attempting not to pollute this precious material by leading questions. The raw material is then purified and processed by means of transcription and analysis.

The traveller metaphor describes the researcher as someone on a journey with a tale to be told at the journey's end. This second metaphor accepts the notion that the researcher is likely to be affected by the experiences of the journey and may change their views, opinions and perceptions through reflection on the experience. The combination of the metaphors leads to the assertion that the purpose of qualitative interviewing is to obtain qualitative descriptions of the life world of the subject with respect to interpretation of their meaning.

Kvale (1996 pp.132-35) then takes the approach of specifying nine types of questions/interventions, which may be utilised during the qualitative interview, ranging from introducing questions through follow-up and probing questions, to interpretive questions.

Whilst at first sight these interventions might seem useful, there are fundamental problems with this strategy in that the interviewer would appear to be leading the subject down a path of the interviewer's choosing rather than the respondent's. The strategy would appear to more closely follow the analogy of the traveller on a package tour, rather than the miner.

Throughout the literature on qualitative interviewing, there is an emphasis on the development and maintenance of rapport and there is the notion that information which may be of a sensitive nature needs to be gleaned without causing any psychological or emotional damage to the respondent. The need is stressed for the interviewer to establish a balance of objectivity and subjectivity which will facilitate the respondent to freely give the information whilst not contaminating the information with the interviewer's interventions.

The skills of rapport development and focused, sensitive questioning techniques, which facilitate the respondent to give relevant information, which is then understood by the interviewer from the point of view of the client, bear striking similarities to the skills needed for effective counselling and therapy.

Interview Methods

As I have had several years' experience as a counsellor and therapist, it was decided to utilise some of these skills in the context of the qualitative research interview, in particular some of the skills derived from the field of Neuro Linguistic Programming (NLP).

Bandler and Grinder (1980), who were students of psychology and linguistics respectively, developed NLP in the early 1970's. Their work was developed by observing, studying and modelling leading psychotherapists at that time. The three main therapists observed were Fritz Perls (gestalt therapy), Virginia Satir (family therapy), and Milton Erickson (hypnotherapy). From their study they were able to recognise linguistic and behavioural patterns, which they were then able to analyse and later replicate.

Of particular relevance to the methodology of this study and the facilitation of qualitative research interviews are rapport skills and a questioning strategy, which Bandler and Grinder termed the meta model. This model was originally developed (Bandler and Grinder 1980), from the work on Transformational Linguistics by Chomsky (1965). One major difficulty with the study of NLP, however, is that there is a virtual absence of further recent research material in the field.

There have, however, been several books written of varying quality on the subject. Whilst it is not the intention here to produce a definitive NLP bibliography, the writings of O'Connor and Seymour (1990), Hall and Belnap (1999), O'Connor and McDermott (1996) and Knight (1995) contain useful further detailed descriptions of rapport skills and the meta model questioning techniques.

Rapport Skills

Rapport skills are amongst the earliest set of skills observed and modelled by Bandler and Grinder. In their observation of Virginia Satir undertaking Family Therapy sessions, they noticed how she had a particular talent for the

establishment of rapport, and from their observations came the following assertions:

- Where people are in rapport with one another, there is a matching of much of their verbal and non-verbal behaviour; the deeper the rapport becomes, the more the similarities become marked.
- In terms of non-verbal behaviour, this consisted of matching of postures, gestures, head nods etc., even including breathing rates and blink rates. Much was also matched in the non-verbal content of the speech - for example the volume, speed, pitch, timbre, tonality and general rhythm of the words used.
- Bandler and Grinder also noticed that there was also a matching of certain linguistic patterns, particularly in the area of predicates and metaphors used.

These predicates and metaphors were classified into Visual, Auditory, Kinaesthetic, Olfactory and Gustatory corresponding to the five senses (Olfactory and Gustatory being much less common). Some examples of predicates and expressions are as follows;

Visual	Seeing things in a different light Getting a perspective on things Looks Bright Focus
Auditory	Being in harmony with Things sounding right Sounds like Rings a bell
Kinaesthetic	Having a grasp of things Things feeling right Get things moving Get the feel of what someone is saying
Olfactory	Smelling a rat
Gustatory	A taste of things to come

The notion of establishing rapport utilising the NLP techniques is based around the listener being aware of the body language and the linguistic patterns used by the subject and matching these.

The net effect of the matching is that the client in therapy and the subject being interviewed feels comfortable very quickly, rapport being established swiftly.

Rapport was achieved, as in the pilot study, initially by matching the body posture, gestures and breathing rate of the interview subjects. Several of the non-verbal elements of speech were also matched - for example the speed, volume and intonation of the subjects. All of this was done without subjects appearing to be aware of this, as none of the subjects made any reference to this during the interviews, neither did they, at any time, appear uncomfortable with this. At one point in each interview, around the half hour mark, I made a point of shifting my posture, usually from a leaning back to a leaning forward posture. In every case, the interview subject did likewise. I took this, in conjunction with the free sharing of data, as a measure that rapport was established and was being maintained.

In addition to matching the non-verbal elements of the subjects, the preferred representational mode of the subjects was established and maintained. There were two methods for this as described by Bandler and Grinder (1980), eye movements and predicates. Predicate is defined by the Cambridge Dictionary online (2003) as

(in grammar) the part of a sentence which gives information about the subject for example, in the sentence 'We went to the airport', 'went to the airport' is the predicate.

(http://dictionary.cambridge.org/define.asp?key=predicate*1+0)

The eye movements of the subjects were noted as they spoke, upwards movement indicating visual processing, downward movement indicating kinesthetic processing and middle distance staring indicating auditory processing. In all cases the predicates utilised by the subjects were in agreement with the eye movements observed. For example; whilst looking up

the following visual predicates were used (all quotes are from separate subjects and predicates underlined)

‘ That is not how I see interprofessional or multiprofessional education.’

‘ it was annoying to see that a lot of them didn't know how to do practical procedures, or anything like that.’

‘ well I suppose I have a fairly pragmatic view.

‘within a curriculum focused on the practical problems encountered in everyday practice.’

‘ I can see when I'm getting better, but it's only when you've got better that you see it. ...so that was a real bit of an eye opener for the nursing staff.’

‘ we are looking at preparing those people through probably foundation degree type routes.’

A typical response from the interviewer to a predominantly visual set of predicates was as follows;

‘so do you see that is being...’ or ‘What would your view be on....’

Whilst the eyes were de-focused and staring into the middle distance, the following auditory phrases were used, both examples were taken from separate interview subjects. It is noteworthy that there were much fewer examples of auditory predicates being used than visual or kinesthetic. The reasons for this have not been explored, as it did not seem relevant to this study. What was important was to notice the types of predicates being used and to match them.

'we need to listen much more to what people the users and the carers are saying, I know everybody says that but they pay lip service to it.'

'that provided quite an opportunity to hear about their direct experiences.'

A typical response of the interviewer to a predominantly auditory set of predicates was as follows;

'Have you heard what other nurses are saying about this?' or 'Can I check that what I heard you say was...'

Whilst looking down, and usually to the left, the following examples of kinesthetic expressions were used.

'you have to be a prime mover and shaker on this, and I think we have the sort of levers that we need to do that.'

'I do feel that it was something that had to be worked through.'

'They take on caseloads and that puts them under pressure as well. They feel that they have to adapt really quickly and not take the time for the preceptorship period. So they are all sorts of pressures on them and it is quite a shocking time for them.'

'there is a language barrier. I feel very strongly that the consortia needs to support to those kinds of things, it needs to work together

very closely with the local provider institutions... Because we need to find a way of assertively out reaching these individuals.'

Typical responses to a predominantly kinesthetic set of predicates was as follows;

'yes the whole emphasis has shifted hasn't it?' or 'one of the things that project 2000 was supposed to do was to move students away from being employees wasn't it?' or more simply 'what do you feel about that?'

In addition to utilising predicates, the interview subjects frequently utilised metaphors which also indicated how they were processing their information.

'we've got to make sure that we put resources, no matter how small, in to all of the pieces of the jigsaw. Otherwise we'll never fit it together. And that is I think, the purpose of the commissioner. It is to get all those pieces of the jigsaw.'

In this instance, where the interview subject used a kinesthetic metaphor, the interviewer directly picked up on the metaphor and continued working with it.

'thinking about a jigsaw is a really good analogy isn't it? Somebody has got to have the full picture on the box haven't they? Somebody has got to have an idea of what the whole thing looks like.'

Although it is fairly common to mix predicates, the notion is that the interviewer should respond to the overall representation system being used. The following example contains mostly kinesthetic language i.e. 'sense', 'feeling out of control', 'burn out', 'emotional buffer' and 'impact'. Although 'insight' (which is visual), was also used, it is the predominating kinesthetic nature of the quote which was responded to:

'therapeutic attitudes and therapeutic competence in the sense that to be aware of the likely consequences of feeling out of control i.e.

burn out might be to increase the prospects of an individual developing some sort of emotional buffer and insight into the words we might understand interpersonal work to impact on the work as a therapist would be critical here.'

It should be noted that the matching of verbal and non-verbal cues as to how the subjects were processing their information, was not undertaken consciously, and is a skill which has been developed through undertaking therapeutic interviews with clients. The extent to which the verbal matching occurred only became obvious once the transcripts had been reviewed.

Utilising the rapport skill techniques in conjunction with the meta model questioning techniques facilitated the interview subjects to feel comfortable and made the interviews feel informal for the subjects, whilst at the same time they were able to be led very quickly to the heart of the issues being discussed.

Again, as in the case of the rapport skills, a conscious effort was not needed on the part of the interviewer, to be aware of the deletions, generalisations and distortions being used, as this was a skill previously developed doing therapeutic interviews. It is a skill which is fairly simple to learn once practiced, however.

The way that the meta model was utilised in the interviews was precisely as it would have been in therapy, with interventions on the part of the interviewer only occurring when the interview subject appeared either to be stuck in some way, or appeared to be deviating away from the data being sought. For the most part, the interview subjects were facilitated to talk mainly by utilising the rapport skills techniques previously described. As there was a large percentage of input in the interviews from the interview subjects, this was regarded as successful for several reasons;

By asking questions which delved deeper into the thoughts and feelings of the interview subjects, valuable deeply buried material was unearthed. By only intervening when the subject appeared stuck or appeared to be going off at a tangent, the deeply buried material was not polluted by the views of the interviewer.

The raw material was then purified and processed by means of transcription and analysis. However, due note is taken of the second of Kvale's metaphors, that of the researcher as a traveller. This metaphor describes the researcher as someone on a journey with a tale to be told at the journey's end. This metaphor accepts the notion that the researcher is likely to be affected by the experiences of the journey and may change through reflection on the experience. This metaphor seemed to hold true throughout the transcription and analysis phase of the project, particularly as it was decided to do interviewing in a top-down way, from policy makers through to service and education deliverers. It was clear from the transcripts that some of the directions that the questioning took in the later interviews was influenced by the earlier interviews. Some interview subjects directly asked whether I had interviewed particular individuals and expressed an interest in what they had to say on the topic.

'I would be interested for instance in what M had to say, given that I was involved in interviewing him not that long ago for a similar kind of research.'

In order not to unduly influence the data at that point, I agreed to share some of the ideas after the interview was complete.

An interesting issue arose in that some of the interview subjects, particularly the Dean, were so comfortable with the process and were so able to talk about the issue with a passion and without deviating from the point, that interventions on the part of the interviewer were almost non-existent. In that particular interview there were 7980 words spoken, of which 7668 of them were spoken by the subject and 312 by the interviewer. This, although

providing much data about her perceptions, provided little in the way of data regarding the usefulness of the interview techniques.

meta model

O'Connor and Seymour (1990) identify gathering information, clarifying meanings, identifying limitations and opening up choices as four uses for the meta model. In the context of the research interview, it is the first two uses which will be concentrated upon.

The three linguistic patterns identified in the meta model are Deletions Generalisations, and Distortions, examples of which follow - adapted with permission from Bridoux (1998):

Category	Linguistic Pattern	Description	Example	Challenge
Deletions	Unspecified Verb	Verbs which remove specifics about how when where	He helped me	How specifically did he help?
	Lack of Referential Index	Unidentified Pronoun	They don't understand	Who doesn't understand?
	Comparative Deletion	Missing standard of evaluation	I handled the situation badly	In comparison to what?
	Simple Deletion	Missing or deficient information	I feel angry	About what?

Category	Linguistic Pattern	Description	Example	Challenge
Generalisations	Presuppositions	Beliefs which a sentence implicitly requires in order to be understood	Why don't you understand me?	What makes you think that I don't?
	Modal Operators of possibility	Words which require particular action or imply no choice	I can't do this kind of thing?	How do you know that?
	Modal Operators of necessity	Words which require particular action or imply no choice	I must do this	What would happen if you didn't?
	Universal Quantifiers	Expressions precluding exceptions	Nurses are really caring	All of them?
Distortions	Nominalisations	Verbs transformed into nouns	My indecision is my biggest fault	How and when are you indecisive?
	Cause and Effect	A specific stimulus causes a specific response A causes B	My boss only has to speak to me and I'm afraid.	How does he/she do that?
	Mind Reading	Assuming knowledge of what another person thinks/feels	He doesn't like me	How do you know that?
	Complex Equivalence	Conclusion based on the belief that the outcome will always be the same	You're not smiling, you must be bored	How does one mean the other?
	Lost Performative	Value judgements in which the source is missing	People are generally caring	What leads you to that conclusion?

With practice, recognition of generalisations, deletions and distortions becomes fairly easy and effortless. There is great potential for gathering clear and focused information utilising this model as a questioning technique in the research interview. This potentially was seen to be useful in the individual interviews, when utilised in conjunction with the rapport techniques.

Report from Initial Study

The intention of the initial study was to act as a pilot for the data gathering tools and techniques. Three subjects were interviewed, and the data from the interviews have been analysed to determine whether the data gathering tools and techniques yield data which will throw light on the focus of the study. The data from both the interviewer and interviewee has been analysed, as a major part of the data gathering relies upon the questioning strategy of the interviewer.

Three interviews were recorded utilising a digital speech recorder which is designed to be capable of transcribing speech directly to text dependant upon the speaker having completed a short (20 minute) voice recognition training exercise. Originally it was hoped that, if the interviewee was willing to undergo the training, it would be possible to transcribe the text of their interview directly from the recorder into the word processor. Upon testing this, it was found that the degree of accuracy with this amount of 'training' was very low, and that in reality, in order to achieve anything like 98% accuracy in the voice-to text transcription, it took around 8 hours. It was obviously impractical to ask this of interview subjects.

The recordings, (2 out of three of them) however, were of very high quality, and as around 98% accuracy in voice recognition had been achieved (after 8 hours training), which constantly is improved and updated by the programme, the following method of transcription proved to be useful.

The recordings were transferred to the computer, and upon playing them back through the computer's sound system, 2 out of 3 of them were very

clear. The 2 interviews which were clear were done using an external microphone, whilst the less clear interview utilised the recorder's own internal microphone. The benefits of digital recording, were, however, a bonus at this point, as the computer's sound system was capable of boosting the volume and quality of the third recording to an acceptable level. I then spoke back what had been heard, and the speech was fairly easily and accurately transcribed.

If voice recognition software continues to improve at the current rate, it should hopefully be possible in the near future to reduce the training time to something like the claimed 20 minutes, and for the programme to hold two voice profiles in memory at the same time. This would vastly improve the task of transcription.

Choice of Subjects for Pilot Study

The subjects chosen for the interviews were from three different stakeholder groups as follows;

1. Subject 1 is a nurse teacher
2. Subject 2 is a clinical team manager from mental health nursing
3. Subject 3 is a clinical placement co-ordinator from the consortium

It was hoped that in choosing three subjects from different stakeholder groups, the efficacy of the interview techniques in terms of yielding relevant data, could be tested.

Transcription method

All of the words used by both the interviewer and interviewee were transcribed, except where phrases were repeated, which occurred fairly frequently (particularly in the case of subject 2), for example,

“What I really think is... what I really think is ...”

However, where the language structure changed, this has been included, as it is relevant to the study, and indicates a shift in how the subject was structuring their experience, for example,

“My view of the situation is...my feeling is...” (subject 1)

The first statement being visual and the second kinaesthetic. (please see Appendix 3 for sample transcript)

Analysis of data from initial Study

The analysis of the data from the initial study has been conducted in the following stages:

- Word count of the interviews, which would identify the relative contributions to the interviews of the interviewer and interviewee. It was felt that, if the techniques worked, the interviewee percentage will be high, hopefully above 70%, which might indicate that the subjects felt comfortable enough to be able to talk freely.
- Search of the transcripts for evidence of representational systems (Visual, Auditory and Kinaesthetic language patterns) and whether the interviewer matched these patterns. It was hoped that this could be seen fairly clearly and that the usefulness of this as a rapport building technique could be seen.
- Search of the transcripts for Generalisations, Deletions and Distortions, whether the interviewer challenged these and whether this led to further useful information. It was hoped that it could be demonstrated that this questioning technique would be shown to be useful in unravelling information.
- General analysis of the usefulness of the data to the focus of the study.

It is worthy of note that during the conducting of the interviews, the interviewer was not making a conscious effort to listen for particular linguistic structures and to match them as this is a skill that had been developed previously and the interviewer was fairly confident in its use. From the recordings, it is not possible to observe the postures and gestures of the subjects and interviewer; however, it is noticeable how the voices of both parties in all three interviews, shared some commonalities in volume, speed, pitch and general intonation. This, as already noted, is seen (Bandler and Grinder 1980) as a positive indication of rapport.

Analysis of Word Count

Interview Number	Interviewee Percentage	Interviewer Percentage
1	76%	24%
2	83%	17%
3	86%	14%
Average	82%	18%

The average contribution of the interviewee at 82% is quite high, and would tend to suggest that they felt comfortable enough to enable free speech on the topic. It is noticeable that with each interview, the percentage of interviewee contribution increased slightly. This may have been idiosyncratic, or, as they are numbered in the order that they occurred, it may have indicated that the interviewer was becoming more comfortable with the method. This can be monitored when the full study is undertaken.

Analysis of Representational Systems

Interview 1

This interview began with the interviewer introducing the topic and asking the subject what the topic meant to them. The subject then continued the interview utilising kinaesthetic language; there were lots examples of this such as wanting to “*move practice on*” and “*things fitting into place*”.

The interviewer followed this linguistic structure with words like “*how does it fit together then?*” At one point, fairly early in the interview, the subject

began to talk in visual terms about how he “...*saw practice changing*” and “...*you are looking at how your knowledge comes from a range of 'ologies'.*” The interviewer responded with, “*So it's knowledge and skills we're looking at then?*” For the remainder of the interview, the subject reverted to kinaesthetic language, and the interviewer followed this.

Interview 2

In this interview, the subject spoke almost exclusively in kinaesthetic terms, examples such as the following are taken from the transcript

- *A blanket of skills*
- *We can pick up very quickly if problems arise*
- *I would put the emphasis back on practice*
- *Let's get away from the classrooms*

The interviewer, once again, utilised the same kind of linguistic structure, examples of which are as follows;

- *Fitness for purpose, on the other hand...*
- *So how do you feel about that then?*
- *Where does the preceptorship period fit in with this?*

Interview 3

The subject in the 3rd interview, seemed to fluctuate between visual and kinaesthetic language fairly rapidly, and sometimes within the same sentence. Consider the following;

“I think that the feeling (Kinaesthetic) for me is that we don't really get brilliant (Visual) students very often, we don't often get people who shine,(Visual) that are very, very, good.”

The dialogue in this part of the interview ended with,

“I'm looking for someone who has the potential to move on, and I'm not really convinced that these individuals have that”

The interviewer answered with a kinaesthetic response.

This pattern was repeated at several points in the interview, with the subject rapidly fluctuating between representational systems, (mainly Visual and Kinaesthetic) and the interviewer responding by utilising the last representation system used in the dialogue. This appeared to be quite successful in making the subject feel comfortable in the interview situation, particularly as this interview was the highest percentage participation of all three of the subject. (86%)

Deletions Generalisations, and Distortions

The following are examples of some of the Deletions, Generalisations and Distortions found in the interviews and the challenges made to them.

Interview 1

“I believe you can teach people exactly how to do a particular skill and they can mimic it to quite high-level, but fitness for purpose is recognising situations when that particular skill is needed and the situations when it is not needed and the situations where it can be adapted and the situations where it can be developed”

This was fairly early on in this interview, and is a fairly clear statement, if somewhat convoluted. What was not clear here is how the concept of fitness for purpose was being manifested. (Deletion – Unspecified Verb) The challenge to this deletion was as follows

“Could you give me a specific example of that?”

This, being a closed question, returned a fairly straightforward response of

“Writing care plans”

This response was seen as a Cause and Effect distortion, and so the question was asked as to how fitness for purpose would manifest itself in the writing of care plans. This then led into a really useful dialogue about the subject’s ideas of the various different ways that fitness for purpose could be manifested, and gave the interviewer a clear view of how this concept was experienced by the subject.

Interview 2

“I think there should be fitness for practice that, definitely then, I know that the end of the training comes and then they require to

have all these general skills but they would not be expected to take on a speciality role, it might be playing with words but, to me you train for a purpose but that purpose is not a speciality.”

In this extract, the notion of speciality role has not been clarified, nor has how the nurse can take on this role. (Unspecified Verb) The challenge to this generalisation was therefore as follows;

“how would you define speciality?”

This challenge led to a precise description of the concepts of general skills, speciality skills and how newly qualified nurses might be expected to take on these roles.

The interview continued by the introduction of the concept of ‘core skills’. The subject was once again asked to specify how she was using the term. This led to a really useful dialogue around her belief that there are two distinct levels of core skills. At the level of the Common Foundation Programme, there are a set of core skills involving basic communication skills and the skills of caring for people. At the level of the Branch Programme, a different set of core knowledge and skills was defined which were special to mental health nursing, for example a knowledge of psychiatric illnesses and their treatment, and skills like advocacy and counselling.

Interview 3

“So you would expect them to be safe, you would expect them to be able to begin to demonstrate leadership skills, management skills, you would expect them to have some kind of understanding of the kind of problems that they are going to be dealing with.”

The 'them' referred to had previously been specified by the subject as being newly qualified staff nurses, so the generalisation was not challenged here. What was challenged was the simple deletion of precisely when would this become an expectation in the following response by the interviewer:

“so would you expect that as soon as they qualify?”

This led the subject to be very precise in articulating what would be expected immediately upon qualification and to say how this might develop during the preceptorship period. (the first six months following qualification)

“I would expect to be able to see the makings of that, I would expect them to land on the wards not being the perfect end product, but certainly have some awareness that would make them ready to start on the preceptorship period.”

The concept of how that awareness would be manifested (Unspecified Verb) and what the 'perfect end product' (Lost Performative) might look like, were issues which were then pursued.

A further example was the following

“I'm thinking about a different level of practitioner that has that responsibility built-in as part of their role.”

The notion of responsibility is here unspecified (nominalization) and the challenge to this was as follows

“Do you want to say more about what you mean by responsibility?”

This led to a precise definition of the subject's perception of responsibility with the added information given that she saw the concept of responsibility as being central to her ideas of what constituted fitness for purpose.

Usefulness of the data to the focus of the study.

Although all of the interviews were fairly brief (around 40 minutes each), the subjects all, throughout the interview process, spoke very freely about their experience of the notions of fitness for purpose, practice and award. By the challenging of the deletions, generalisations and distortions which occurred, the lived experience of the subjects in relation to the concepts was unravelled and progressively focused, and they were able to talk very specifically about how they understood the terms and how they were using them. After the interviews were over, all three subjects remarked upon how much more clearly they understood the concepts having been given the opportunity to examine and explain them to the interviewer.

It was therefore decided to utilise these techniques in the full study, as they would appear likely to provide highly useful data to throw light on the focus of the study.

Analysis of data

Tesch (1992) identifies 46 types of qualitative research, clustered into four types along a broad continuum ranging from highly structured and concrete, to less structured and more interpretive. The four types are based on

- characteristics of language
- discovery of patterns and regularities
- comprehension of meanings or action
- reflection

A further typology can be found in Crabtree and Miller (1992) As follows;

- quasi-statistical Methods
- template approaches
- editing approaches
- immersion approaches

A fifth type is added by Drisko (2000) who introduces what he terms action oriented approaches, which is described as falling between editing and immersion. From the kinds of data generated, and the research questions asked, the very formal quasi-statistical methods are probably not appropriate as it is the lived experience of the subjects which is likely to lead to useful analysis.

Looking for relationships between perceptions, expectations and potential ways of managing the stakeholder relationships might lend itself more to some kind of Logical or Matrix analysis as argued by Miles and Huberman (1994); however, the intended results are around understanding the worlds of the key stakeholders. Matrix analysis may have yielded a thick description and perhaps some typologies, but in seeking to understand the lived experience of the stakeholders, a hermeneutic, phenomenological approach would appear to offer the more useful framework for data analysis.

A software package QSR NUD*IST was utilised to analyse the data. The NUD*IST acronym stands for Non-numerical Unstructured Data Index Searching and Theorising. This package greatly assisted in coding the data into an index system, searching for patterns in text and in codes and in theorising about the data. It proved to be a really useful and flexible tool.

Taken in conjunction with the flexibility offered by QSR NUD*IST as an analysis tool, the data lends itself well to accessing the lived experience of the subjects. The interpretation of the text is done utilising QSR NUD*IST to access the experience utilising the notion of distancing as follows:

Ricoeur (1981), cited in Cronin (2001) describes four principles of distancing in analysis of data.

Ricoeur's four principles of Distancing	
First form of Distancing	Transcription of dialogue: it becomes text and is fixed
Second form of Distancing	Relationship between the written text and the original speaker
Third form of Distancing	The text is freed from the original audience
Fourth form of Distancing	Addressed to a wider audience, all readers.

The first form of distancing takes place upon transcription of the interviews into text, which in itself required the interviews to be listened to several times to gain an overview of the context. Once transcribed, the object of study then becomes the text itself. The text was then read and re-read several times to view the data as a whole, looking for contextual meaning. Upon completion of this stage of analysis, it became clear that it would be most useful to use each line of text as a text unit for analysis. The software has, however, the facility to spread the text unit to several lines, where the line does not convey the meaning. Lines of text then acquired meaning in relation to sentences and paragraphs then were allocated categories based upon their relationship with one another. In this way the text was freed from its context and the deeper meanings can be understood.

This is particularly important, given that the study is concerned with studying both the data gathered from the subjects during the interviews, and the language utilised by the interviewer. Both sets of data have been analysed in the same way as they are inextricably linked to one another.

Despite the assertions found in the study by Green and Holloway (1997) that phenomenological studies rarely venture beyond a sample size of four, as that tends to generate more data than can be effectively analysed, it was decided to continue with this methodology, but to aggregate the data in relation to natural groupings of stakeholders. In this way it was

felt that the methodology which showed the most promise for uncovering the data for the project, would not be rejected for reasons of being potentially too difficult.

Given that the central focus of this study is to determine the extent to which the present pre-registration education for mental health nurses is perceived to be appropriate to the needs of the Health Service by the major stakeholders, an analysis of the data using hermeneutic phenomenology as a framework for analysis would appear to offer the potential for the best available method to understand and subsequently analyse the data as it needs to reflect the lived experience of the phenomena from the perspectives of the subjects, as described in Parse *et al* (1985).

Chapter 4 - Findings

The research questions form part of the basis for the presentation of the findings. However, as the interview methodology was also analysed, further findings relating to the use of the meta model as a tool for interviewing are included.

Generalisability of the findings

The issue of generalisability in qualitative research is fairly contentious and has been much debated in the literature. Schofield (1989) describes various positions ranging from the active rejection of generalisability in qualitative research by writers such as Denzin (1983) through to an increased interest in generalisability in qualitative research over the past decade. Several writers make this point (as cited in Schofield's work) such as Patton (1980), Guba and Lincoln (1981) and Stake (1978). Schofield continues by attempting to re-conceptualise generalisability firstly examining the concepts of comparability and translatability, as described by Goetz and LeCompte (1984).

Comparability relates to the notion that the components of a study, and in particular, the results, can be utilised by other researchers as a basis for comparison.

Translatability has a similar meaning but relates more to the methodology of the research. Both comparability and translatability are discussed in relation to this study. Schofield further cites the concept 'naturalistic generalisation' described by Stake (1978), where the findings of one study can be applied to understanding similar situations. This notion of naturalistic generalisation is also a useful way of drawing conclusions from this study.

Schofield (1989) argues that there are three targets or domains within which qualitative researchers can usefully generalize, which are described as 'what is', 'what may be' and 'what could be'.

The 'what is' domain relates to studying the typical. Cases are chosen on the basis that they are typical of what is generally happening in that particular field. To a certain extent, the case studied here can be said to be typical for the following reasons. As previously stated in the introduction, the course chosen for this study is typical of all Project 2000 courses in that the curriculum is derived from a national Outline Syllabus. All Project 2000 courses are conjointly validated by the English National Board for Nursing, Midwifery and Health Visiting (ENB) and a higher education institution.

The 'what may be' domain relates to studying the leading edge of change. Cases here are chosen on the basis that something atypical is happening and that studying what is happening within a case where innovation is occurring may point towards new types of thinking and further innovation. The case chosen for this study also shows elements of leading edge change, again as described in the introduction, the university has been successful in its bid to become a site to deliver one of the initial demonstration sites for the 'fitness for practice' new type of training.

The 'what could be' domain relates to studying the unusual to determine what makes a particular case unusual or particularly successful. I believe that the case studied here is unusual in that there appears to be particularly good, positive and supportive relationships between stakeholders, which was particularly evident in studying the minutes of the contract monitoring meetings. The findings in relation to the innovative interview methodology could also be included under this domain.

There was a surprising amount of agreement between stakeholders as to their perceptions of what skills, knowledge and qualities were required of the mental health nurse. Furthermore there was much agreement as to the kinds of skills, knowledge and qualities, which, if they were not present, would indicate poor quality. Each stakeholder group, whilst demonstrating agreement on the above issues, did each hold a unique set of perceptual filters which had their own interests uppermost. In other words they were

primarily concerned with their own special or specialist area, and less concerned with the broader issues.

The stakeholders interviewed, were grouped under the following headings, (set out below) representing their main interest areas. Each of the stakeholders held as most important, that main area of interest identified, and perceived the issues primarily from that perspective. There was, in some cases, particularly at a senior level in the stakeholder groups, an understanding of the concerns of other stakeholders, but this was always of secondary importance.

In order to attribute the generic source of the data extracts, whilst still preserving the anonymity of the respondents the following keys will be utilised.

SD = Service Delivery (followed by a number to indicate respondent)

ED = Education Delivery

UC = Users and Carers

***'I keep contact with nurses in the system, I like to keep in contact with clinical staff. Because in the job I do I need to have a sense of what their world is like.'* (SD2)**

This phenomenon could be described as a set of perceptual filters or ways in which the world is seen from a particular point of view.

Main area of interest	Stakeholders	Main role	No interviewed
Delivery of mental health services	Department of Health	POLICY FORMATION AND DISSEMINATION	1
	Education Consortium (later to become Confederation)	Workforce strategy planning, negotiation and allocation of funds between the education providers and the Service providers	1
	Health Authority	commissioning of health services, delivery of the modernising of the health service agenda	1
	NHS Trust Managers	managing the delivery of health care	3
	Qualified Nurses	direct delivery of health care	6
Delivery/consumption of education	Students	consumers of education which enables them to provide care	6
	Nurse Teachers	Providing education to facilitate students ability to provide care	5
	Education Managers	managing the delivery of education	2
Needs/rights of Service Users and Carers	User and Carer Groups	protecting the interests of the specific users and carers within their remit	4

In order to make sense of the data, it is important to firstly specify the findings around how those main areas of interest were demonstrated by the stakeholders interviewed.

Service Delivery.

Within the category of service delivery, each of the stakeholder groups appeared very clear as to their place in the scheme of delivery of mental health services. The Department of Health talked about receiving information from a wide variety of sources, indeed from all the stakeholders, and then using that information to ensure that policies which facilitated the care delivery, were in place to assist the organisations directly involved in delivering that care. Their role was therefore seen as one of policy making.

*‘So my perspective is really from an organisational delivery one and it's very much on the basis of information received from a whole host of sources, from Chief Execs to users and carers.’
(SD3)*

The confederation (formerly consortium) again saw that gathering of information from all stakeholders was important, but that their main contribution was in the production of a workforce strategy which ensured that the staff delivering care were equipped with the necessary skills. This perspective appears to be based around the production of a workforce strategy, which would include provision of the education considered appropriate to realise that strategy.

‘It's about the confederation having a workforce strategy so that we know exactly what it is that we need to develop the work force in mental health in providing mental health services – who is going to deliver that care, what sort of training do they need, how are they equipped, how do we address their needs. I suppose the continuum from the new recruit to the existing work force and we have that continuum to try to ensure that we are skilling the practitioners to do the work that they are supposed to be doing.’(SD2)

The Health Authority talked about their task and perspective being about implementation of policy, which would mainly be achieved through having people in place with the right blend of knowledge skills and attributes to ensure the delivery of mental health care as defined by meeting governmental targets for mental health.

'I think my own particular take on this is, the strategic agenda on mental health has just gone absolutely crazy really. So the work I have been involved with in the modernisation agenda shows that I think there are about 79 or eighty outstanding items of mental health policy at the moment. So education and training becomes one sort of football, on the pitch, although one of the things I am trying to do locally is to tie everything together into a very broad workforce arena, because the key things, you know if you are going to change anything it's not done through machinery, it's not done through buying more computers, or buying new buildings and new cars and more paperwork, it's done by investing in staff.'(SD3)

Service managers were very clear that there was a specific set of attributes, skills and knowledge which were required in order to do the job of looking after patients. The perspective here was clearly about the direct delivery of care and what the requirements were for being able to do that effectively.

'If I think about psychiatric nursing skills I think about interpersonal skills being at the top of the list, I know that I have said that already, however, I believe that you have to be able to communicate with individuals, you have to be able to help them, for instance, manage their distress, you have to be able to deescalate situations before they get out of hand. You have to be able to deal with somebody who is very, very agitated, who is very irate, who is very weepy, who is very distressed. And I think if you don't have that, then you are going to struggle.'(SD5)

Qualified nurses appeared also to share the managers' perspective that it was clearly important for staff to have a specific set of skills in order to care for patients.

'My belief is that there is a separate set of core skills across the board for all disciplines, and then there are a separate set of core skills applicable to mental health, so I see two separate sets of core skills. There are the core skills I would expect them to have at the end of CFP like grass roots nursing across the board, but then there is the next level of core skills that I would expect in the branch programme. So at the end of the, like, mental health Branch you would have a basic all-round knowledge of psychiatry as well as all the general skills of looking after people.'(SD8)

The world of the service delivery stakeholder can be said to be characterised by the following

- Mental health policy is created by the Department of Health.
- Policy arises as a result of wide consultation with stakeholders.
- The confederation creates a workforce strategy acting as a negotiator between the trusts who have skills requirements and the education providers who are able to help develop those skills.
- the Health Authority ensures that change is delivered through staff.
- The trust managers and staff directly deliver the care to patients and are clear on the skills, knowledge and attributes necessary to deliver that care.

The stakeholders from this group were therefore very focused upon a specific set of skills, attributes and knowledge which were required by those giving first-hand care to clients. They were very clear as to what they believed those skills, attributes and knowledge to be.

Education

The teachers and education managers in this group have similar major areas of interest, whilst the students' major areas of interest are quite different.

The education managers' perspective is about the creation and subsequent management of the delivery of a curriculum which meets all of the requirements of the stakeholders. This firstly means finding out what the stakeholders want, by forging strategic alliances with them, then somehow matching that to the strengths available within the school.

'... have a good hard look at the things that you have got locally and to decide what you are really good at. In terms of how you contribute to the future agenda, which means understanding what the agenda is and rebuilding alliances really. And really focusing on something so that you see it through and to produce it, otherwise there is a danger that you tried to do everything, and actually you do not build those partnerships on the ground.'(ED12)

There appears to be an acute awareness that the university will be judged on the output of the educational delivery, the skills, knowledge, attributes and qualities of the students at the point at which they become qualified nurses.

' We don't intend to produce anybody who is a specialist at the point of entry to the register. But what we do expect is to produce a practitioner who is safe at the point of practice, who is self-aware and knows their own limitations. And also post registration is a lot wider but I think that we need to be looking at, this is what the newly registered practitioner has, because they should have got through if they don't have those skills, let's look at that as part of the post registration model, and let's think what do they need on top of that to function effectively as a staff nurse, or whatever grade they are?'(ED13)

The teachers' perspective is firmly rooted in the notions of what it is that needs to be taught to the students in order that they function effectively as qualified nurses at the point of registration.

'... my preference would be for mental health nurse training to be firmly located in the interpersonal domain. It seems to me that interpersonal skills provide the corridors or vehicle through which any care is possible. I would have to have a rider to that because we have this language problem – almost anything we say is a bit tired, a bit clichéd. So when I think about interpersonal skills, I'm not uniquely referring to specialised counselling skills and so on – but I am thinking more, rather about interpersonal competence required in a range of typical and specific interaction contexts that are characteristic of the normal practice of the mental health nurse.'(ED8)

In addition to a focus on what is to be taught, there is an emphasis on how that should be done. There is a clear perception that the way things have been done in the past has not served the stakeholders well and that other ways need to be found to integrate theory with practice.

'... we have to address the divergence that exists between the two extremes of pure practical training for nurses on the one side and unduly philosophical or theoretical approaches on the other. A third way is to synthesise the two approaches through strengthening the learning environment in a way that integrates the practical learning experience with the theoretical underpinning central to the nursing programme. This will be achieved through assembling a comprehensive set of real case histories that capture the patient's care experiences and their associated nursing care. The case histories will then be mapped to the key learning outcomes of nursing curricula and scripted to provide learning materials that enable student nurses to engage with and problem solve within a nursing/patient context. These materials could be further developed to form the basis for a nursing curriculum that integrates theory and practice, is practice driven and derived from practical problems encountered in everyday practice.'(ED11)

The students seemed, on the whole, to have given little consideration to how the curriculum is designed, and to the thinking that went in to its creation. They appeared more directly concerned that what they were learning should have some kind of practical use in their current practice, and for when they qualify.

'I've no idea how they decide what they are going to teach us and when – I suppose there is some kind of master plan somewhere, but I don't know what it is'(ED2)

'Some of the subjects and the way they are taught are hard to relate to – I can see the sense of psychology and sociology but some of the other stuff is just what I have to learn so that I can pass my assignments and the course at the end of the day.'(ED5)

There is an interesting split in the focus of this stakeholder group – the teachers and managers are focused upon the delivery of the curriculum to meet the needs of the stakeholders, including the students. The students appear to be more focused upon the utility of the course, in terms of how it will help them to perform in their future practice. There is a common utilisation of the possessive when students talk about the course:

'my course'

'my training'

'my assignments'(ED 1-6)

the implication here, being that it is a product which was created for their individual benefit, owned by them, consumed by them and providing them with the licence to practice which they needed.

The students' views appeared not to have significantly altered from the findings of the study done by Parker and Carlisle (1998), who found that students had an overall positive view of their course in that they appreciated the value, relevance and breadth of their training, but felt that the programme

lacked coherence and organisation and at times were dissatisfied with teaching methods utilised.

The world of the education stakeholder can be said to be characterised by the following:

- Education managers, through their contacts, find out what the needs of the stakeholders are.
- Courses are then created, delivered and evaluated by teachers according to the perceived needs of the stakeholders.
- Students consume, value and own the course they are studying.

I found that the service user and carer groups were extremely focused upon the precise area in which their interest lay, without showing much interest in the broader picture. For example the Samaritans were very interested in the training given to mental health nurses in depression and suicide prevention,

‘... as you know, we deal with people who are desperate, in crisis and suicidal – how much training do mental health nurses have on that? I don’t think you could ever get enough of that. Sometimes, even with the training and years of experience I’ve had, I feel really inadequate when dealing with somebody in that state. I guess you spend a lot of time on it do you?’ (UC2)

whereas the Alzheimer’s Disease Society were interested in the teaching of their own specific subjects only.

‘I’m sure you know the figures and have read the books, so you will know how important it is for all nurses to be aware of dementia in all its forms and how we can help these people. From what I see of nurses, I don’t think there can be enough in their training to prepare them.’(UC1)

This kind of specific issue focused phenomenon was repeated with all of the user/carer voluntary groups I talked to. There appears to be a not unreasonable, and commonly held belief of each of the groups, that their particular issue is *the* most important issue in mental health. Furthermore, all of the groups were of the opinion that their issue was not sufficiently covered in the training. To the credit of each of these organisations, all of them offered to do some teaching for the university on their particular subject interests.

The service user and carer world is characterised by the following:

- Users and carers are the most important people in all of this, as that is the whole reason for the existence of all of the professional groups.
- The particular interest of each of the groups was seen to be the most important issue.
- Not enough information about that specific issue was included in mental health nurse training.

Perhaps the most surprising element of the findings was the widespread agreement across all stakeholder groups, including the students, as to the knowledge and skills needed, and the areas of perceived deficiency. Furthermore, a series of attributes or personal characteristics emerged which again showed remarkable agreement across all stakeholder groups. Possible reasons for this are discussed later.

Knowledge

There were three main areas of knowledge expressed in the interviews.

- Knowledge relating to the needs of service users and carers.
- Knowledge about mental health and illness.
- Knowledge about research

Needs of Service Users and Carers

There was a clear agreement as to the importance of needing to have an understanding of the needs of users and carers. This was manifested in slightly different ways in each of the different stakeholder groups according to their reasoning for why this was important.

The service delivery stakeholder group was acutely aware that in order to deliver care, they had to be aware of the needs of users and carers. This was given even more prominence since the publication of the National Service Framework for Mental Health set targets for NHS Trusts for the involvement of users and carers.

'There are now huge expectations from Ministers and Statutory Bodies on the performance of services generally and in mental health as well, which is right and proper. Increased expectations as a result of the National Service Framework engagement of users and carers, which has increased quite a lot, and of course it is the people in the front line that have to deliver.'(SD3)

There is an awareness amongst the service delivery stakeholder group that service users' expectations have changed, and that as a consequence, demands on the mental health services to deliver high quality care have increased.

I think that the expectations of users have changed. And they are, and will continue to be more vociferous about what they want and what they don't want. I think that the demands on the NHS have changed substantially.(SD6)

It was perceived that pressure was being brought to bear on the delivery of mental health services from Government policy downwards and from patient/client, user and carer expectations upwards.

The education stakeholder group was also acutely aware that the provision of courses needed to somehow have input from users and carers.

'we need to listen much more to what people the users and the carers are saying, I know everybody says that but they pay lip service to it. I think it is still very weak and we need to get that right.'(ED13)

'I know that the service are really keen now to get users and carers involvement not just in a tokenistic way. I really think they want to get that right.' (ED9)

There was an awareness that in mental health, involving users and carers in a partnership in the design and management of curricula is desirable but quite difficult to achieve in any meaningful way.

' what I'm saying really is that the key element in the NSF for me is the emphasis on partnership. Quite how that would be facilitated as the strategy is developed, is another matter.'(SD4)

One way in fairly common use is the canvassing of user and carer views by proxy, by having service management representatives on curriculum design and management committees. The hope here is that they will bring their knowledge of user and carer views to the committee meetings with them.

'The idea is that the service representatives that we bring in do have their own representative groups and that they consult with the service users, so the idea is that they should be coming in with the issues that their service users represent, that the service users flag up.'(SD11)

The students also had a realisation that in order to care for patients, their needs had to be looked at in the wider context of their families and significant others. This was seen universally as being vitally important. This

concept appears to be well covered throughout the curriculum and seemed well understood by the students.

We are clear about the need to involve users and carers when planning care, it's something that we looked at throughout the course, particularly in the sociology of mental health.(ED4)

How can you care for somebody in isolation? (ED6)

Mental Health and Illness

A good basic, all-round knowledge base in mental health and illness was expected of the students, although from the way in which this was expressed by those interviewed, it appeared that it was taken for granted that this type of content would be included in the course. It was interesting to note that all of the stakeholder groups talked about knowledge as something which underpinned and facilitated the development of skills.

'So at the end of the, like, mental health Branch you would have a basic all-round knowledge of psychiatry as well as all the general skills of looking after people.'(SD7)

There was a general agreement that knowledge clearly had a purpose, and that purpose was to facilitate practice.

'I'd expect them to have an understanding of the different areas of mental health like elderly, forensic, adult acute and to have a very good idea of the different types of interventions and assessments and I would expect them to have obtained experience in these areas and expect them to be competent in communicating at the professional level. They should actually be able to demonstrate interventions with clients at the end of the branch.' (SD10)

It was argued that the strength of the claim of nursing to be a profession hinges upon this ability to develop educationally through practice and to develop practice through education.

***'Because the strength of the profession is in its knowledge and through its knowledge its expert practice.'*(SD8)**

In order to develop professional knowledge in nursing, the curriculum, and in particular, the first 18 months of the course, contains subject matter described by teachers as 'ologies'. The main disciplines here being referred to are physiology, psychology and sociology.

***'you'd be looking at first your knowledge in nursing would come from a range of 'ologies' and other type of sciences and obviously the ability to research and recognise what steps to take in moving towards outcomes.'*(ED9)**

It was also recognised that students need to develop knowledge and skills in research. This was seen as underpinning knowledge which would facilitate skills development. The notion here is that by developing knowledge and skills in research, this would enable nursing theory and skills to change and develop.

***' we should be developing knowledge through research and through scholarly activity. And it should be that research and scholarly activity that allows us to develop nursing, the theories of nursing, the practice of nursing.'*(ED10)**

The ideas of the teachers were clearly about facilitating a deep level of learning though understanding the students' practice at a theoretical level.

'this approach will move the student away from superficial learning towards deeper learning from the materials as they support the student in getting underneath the superficial and explore how differing approaches and theories predicate

differences in nursing activity. The learning environment will develop links to current courses of evidence based practice knowledge and create a dynamic between the clinical context and the wider development of theory. Contextualising learning in this way allows students to translate patient data into information and information in context into knowledge.'(ED8)

There was, however, an acknowledgement by teachers, that a large part of the learning process happens in practice, and is outside of the control of teachers. There seemed to be a sense of discomfort with this notion.

' There is only so much that you could do in education.

A lot of the learning takes place in practice. That has got to be acknowledged.'(ED7)

Skills

Several key skills were seen by those interviewed, to be vital to the role of the mental health nurse. These were either expressed by directly stating that this was a particular need or by identifying that the skills were absent and should be included in the course. The key skills identified were as follows

- Safe Practice skills, including risk management
- Management skills, the managing of people, resources and difficult situations
- Interactive skills
- Collaborative skills

Safe Practice Skills

Due to the supernumerary status of students as a result of the introduction of Project 2000, qualified staff ensure patient and student safety during the course.

‘ when they are students they are supernumerary. That supernumerary status acts as the kind of umbrella at the time, and keeps them safe, in that they are not responsible for their own actions, they are not always accountable because there is always someone in charge of them.’(SD5)

There was, however, a clear expectation that at the point of qualification, students should be safe practitioners.

‘So you would expect them to be safe’(SD5)

The notion of safety was fairly clearly defined as including self-awareness and, in particular, a knowledge of the student or newly qualified practitioner’s limitations.

‘what we do expect is to produce a practitioner who is safe at the point of practice, who is self-aware and knows their own limitations’(SD8)

The responsibility for ensuring the safety of the patients and the students during the course is seen as a joint responsibility between the service and the education providers.

‘we share the responsibility of making sure that the clinical practice in this area is safe’(SD4)

Management Skills

Every subject interviewed talked about management skills, although the precise nature of those skills differed between individuals. This could, in part, be attributed to different viewpoints of different stakeholder groups, or could reflect more generally the wide ranging interpretations generally held as to what management is. The terms ‘management’ and ‘leadership’,

particularly within the service provider stakeholder group, tended to be used synonymously.

‘ you would expect them to be able to begin to demonstrate leadership skills, management skills, you would expect them to have some kind of understanding of the kind of problems that they are going to be dealing with.’(SD11)

Management, for the qualified nurses, was seen as something different to practical or academic skills, and it was felt that the emphasis of the course should be upon the basic practical skills of looking after patients.

‘it (the course) should still be more practical than academic or managerial. To me, I would say that the course should have more emphasis on the practical aspects. Let's get away from the classrooms and actually teach people to look after patients’(SD10)

The views about management tended to cluster around

- Management of self
- Management of ‘the shift’
- Management of situations
- Management of patients and clients

Management of self

Management of self related to the skills related to students being able to manage both their practice and the ongoing professional development they would require as their practice progressed. To a certain extent this was about self-awareness of their strengths and limitations.

‘they certainly don't come out equipped to, it seems to me, manage the change in their own practice.’(SD12)

Teachers saw this notion of self-management as a prerequisite to being able to manage patient care and to manage staff.

‘how can the students learn to manage patients or other staff if they don’t first learn to manage themselves?’(ED10)

Management of ‘the shift’

There was a clear expectation that upon qualification, the student nurse would be able, not only to give high quality care, but to possess the skills of managing other unqualified staff and students through that process. The notion seemed to be about once qualified, it was then up to other staff to give the direct care, whilst the qualified nurse managed that process. The interactions with patients then seemed to be limited to crises or random chance rather than planned therapeutic communication.

‘Often what those (student) nurses are doing is managing the shift.’ And their interaction with clients tends to be reserved for difficult to manage situation i.e. emergency occurrences, or its down to random chance.’(SD8)

Management of situations referred to having some fairly specific and sophisticated interpersonal skills that would help to deal with difficult and challenging situations, for example managing and de-fusing violent and potentially violent situations. This would include a whole set of skills including the recognition of the early signs of a potentially violent situation and then a set of skills which would deescalate that situation.

‘ you have to be able to de-escalate situations before they get out of hand.’(SD5)

The de-escalation of difficult and potentially violent situations was seen as being very high level skills, and when done skilfully, could be quite inspiring to observe. Several of those interviewed, both qualified nurses and students cited a situation where they had witnessed this type of incident as the main reason they had chosen to study mental health nursing.

'one of the student nurses there, she said I had no interest in mental health, I was on my second day and we had a very disturbed patient, I was very frightened, and I saw this qualified nurse talk this patient down and manage the situation and I thought blimey! That's what I want to do.'(SD9)

Management of patients and clients was about having a rapport with clients, and having sufficient communication and interpersonal skills to be able to assist clients to manage their distress.

' I believe that you have to be able to communicate with individuals, you have to be able to help them, for instance, manage their distress.'(SD4)

Management of patients was seen as a difficult set of skills, and one interesting view put forward was that it was much easier for the more experienced qualified nurses to move away from positions in which these skills were necessary, and to take up posts where more general management skills were needed.

' let me put it this way, for a number of staff, I think that actually, they would prefer not to have to deal with patients, because it is quite difficult. It's not easy, you know, these are people in crisis, these are people in difficulty. And some people might not have learned the skills of how to do that. Some might have learned them but they have decayed, some may have been uncomfortable with that and therefore quite happy to move towards more office based administrative, management.'(SD3)

Interactive Skills

The everyday skills of interacting with patients and clients were by far the most commonly cited skill required of the qualified nurse. Every subject interviewed, regardless of their stakeholder group, cited these everyday skills as being the most important skills necessary.

From the most senior policy makers, to the most junior nursing students, all were of the strong opinion that what was required was a set of very basic communication and interpersonal skills. What it was that was being talked about was not sophisticated counselling skills or therapeutic interventions, but really simple everyday conversational skills, coupled with basic skills in looking after people.

'I'd want to know that they had some good that they had some basic interpersonal skills, or at least they would be able to develop those.'(SD4)

An opinion shared by education stakeholders and service provider stakeholders alike, was that the move to a higher academic level of education for nurses, had resulted in a move away from teaching basic practical skills, to teaching more complex theories and skills.

'The kinds of things that come up are sort of throwing babies out with bath waters and I think that looking at a return to getting the basics right again, in that there's been a swing with project 2000 not just with our course specifically, but nationally there has been a lot of concentration on the theory at the expense of practice not looking at the very very basic essentials of practice.' (ED12)

Those 'very very basic essentials of practice' talked about were fairly well understood as being activities of daily living such as helping patients with feeding, dressing and personal hygiene and conversing with them on a very basic, human level.

' how to deal with the activities of daily living, how to feed them, how to, all very basic communication skills and a lot of personal skills as well are needed.' (SD10)

' the thing that users want is nurses in acute wards to talk to them, and it doesn't happen.'(SD1)

There was an acknowledgement that more sophisticated communication, counselling and therapeutic skills were needed, but that these would only be needed by a small minority of trained nurses who could specialise in these types of intervention. This was seen as something which could be engaged upon after the initial qualification and not something which needed to be in the course.

'I don't think that interaction is complicated, I don't see the answer to that as being for everybody to have highly systematic skills training. To some people I think that is important, you will need some people who are able to do that stuff. No this is basic befriending. That's what the people want. That's what nurses are supposed to be trained to do.'(SD2)

Collaborative Skills

There was a further set of skills raised which were seen as vital to develop in nurses by the time they had qualified, this related to being able to work in partnership with others. Nurses were seen as central to giving care, but that care needed to be delivered in partnership with the patient, the patient's carers and with several other professionals from other disciplines. The notion of collaboration was seen as being encouraged by the National Service Framework.

'One of the things that I was really very encouraged by when the NSF was developed was how clear the needs were articulated, and the emphasis on collaboration.'(SD1)

Each stakeholder group interviewed, expressed an interest in collaborating with other stakeholder groups, they also identified that other stakeholder groups were also keen on reciprocal collaboration.

'one of the things that they seemed to be really keen on was the skills involved in collaboration. Actually working with a diverse group of people in getting the views of those people involved.'(SD3)

'There was a very clear understanding amongst everybody about the need to work together.'(ED12)

The notion expressed is that all parties involved in the care of the patient, including the patients themselves, are regarded as partners in the care. They should then be able to negotiate and collaborate with each other to determine the best possible plan of care.

' The notion there is that you have a unit in which everybody is a member of the team including the client, the patient, the relatives, the nurse, the student, the psychiatrist, everyone who's a member of the team who collaborate with each other to decide on standards and then agree a set of set of standards, and evaluate them and get pin points. The notion was that what was most important in that was the fact that people had the skills of being able to negotiate and come to a shared understanding of what care is about.'(ED1)

This does call for some fairly sophisticated communication and negotiation skills, not least, because some of the patients, due to their mental state, may not be completely rational, and may not be fully able to articulate their needs.

Attributes

There were three main attributes which were seen by the subjects as being vital in a qualified nurse as follows;

- Motivated
- Team Player
- Confident

The quality of being motivated was seen as needing to be present in students as well as in qualified staff. It was seen in some ways as a necessary precursor to being able to develop in to a good qualified practitioner.

‘ if they are good students and they are receptive, and they are motivated, and they are thinking about their own practice and thinking about developing that, to my mind that seems to be to make them better staff nurses.’(SD6)

Being motivated was described not only in terms of having a positive attitude towards learning about nursing and developing skills, but also referred to having a positive attitude towards the trust and their study at the university. Possessing motivation was one of the major attributes sought after by managers selecting newly qualified staff.

‘I am looking for people who are motivated to being able to develop their skills, motivated towards the organisation that they are working for.’(SD5)

In some ways, the qualities which were engendered in the students, and, in particular, motivation, were seen, by some subjects as being of even higher importance than knowledge or skill.

‘they could have lots of knowledge and skills but if they’re not motivated it’s just useless.’(SD8)

The teachers felt that this type of quality was one which was not directly taught through the curriculum, but was facilitated throughout the programme. To a certain extent, teachers, when selecting students for the course, were looking for this ‘self-starter’ or motivated quality.

'we need self-starters, that's not something we can teach them – they come with it to a certain extent, we just help to bring it out in them.'(ED10)

Another quality which was highly valued was the ability to be a team player. This relates directly to the emphasis being placed on the skills of working in teams and the culture of collaboration in care which is being promoted throughout the NHS.

'I think I would be looking for somebody, who could obviously demonstrate that they could get on with individuals and so they could work as a team and take part in being a team player.'(SD11)

This quality was also seen by education managers and teachers as being of very high importance to the success of nurse education.

'if you can really identify what the secret formula is ,(for developing teamwork) put it in a bottle and pour it into every single education and training programme, then we might stand a chance of getting somewhere really.'(ED12)

This notion of team working would include the possession of shared values amongst team members and about members of the team valuing each other's contribution to care.

' it's about a team working and it's about values and valuing every single member of that team.'(SD10)

Furthermore, the success of the interventions in care was also seen to be dependent upon this quality being present.

' it is quite clear that students learn, or as they learn, they learn to appreciate that they need to interact as a member of the team. And that the most effective progress in care particularly with

clients who have complex and difficult problems is via a process of consensus on the way forward.’(ED8)

A very useful point was made that there is an emphasis placed, particularly in the latter stages of the course, upon leadership. If more emphasis were placed on teamwork, and what was termed by one of the subjects as ‘followership’, more collaborative skills might be learned and partnership in care might be more easily facilitated. The point was made, however, that this applied not only to nursing, but to all professional groups.

‘there generally, is a gap in all pre registration trainings, for all professions which is actual sensible training in teamwork and how to work in teams. Because mental health is a team business, you can't work in isolation and yet we train in isolation, and people practice their training in isolation. They get into situations thinking they are going to fulfil the nursing role, the doctor's role, the social worker role – actually how to work as a team, for some people that's really quite difficult. If you've not been trained in what a team is and for example I mean at its simplest we talk about leadership, well we need leadership but by God we need followership as well.’(SD5)

Confidence

Self-confidence was also cited by both educational and service provider stakeholders as being a vital quality in students and in trained staff. There is also an element of self-awareness embedded in how the concept was expressed, in that the students were expected to recognise if confidence was a problem and be able to do something to remedy this.

‘I think I would also want to see some evidence of some confidence, and if they recognise that that is an issue for them that they can do something about it.’ (SD9)

The quality of confidence was expected to enable students and qualified staff to challenge established practice, in the manner that Project 2000 envisaged creating the knowledgeable doer who would question and challenge established ways of doing things. This was, however, at present, seen by service provider stakeholder groups, as being lacking in the current students.

'They don't seem to have the confidence to be able to challenge what is going on in the environment, or ask questions about what is going on in the environment.'(SD6)

The teachers valued the quality of confidence, and again, saw confidence as a pre-requisite to being able to comfortably challenge established practice and to facilitate change.

I would recognise it (a skilled practitioner) by the confidence that they have in themselves and confidence they have in dealing with other people and situations and also by seeing someone who is innovative and able to create change. Someone who isn't afraid to try things out You know someone who could be seen to be making positive changes and even if they make changes that are not rock solid they'll say that tried but it didn't work.'(ED11)

Students also valued confidence as a quality, and was one which they expected to be gained by developing their knowledge and skills throughout the course.

'I felt really nervous on my first placement, and that got less the further I got through my training – I think once I feel like I know what I'm doing, I'll be OK.'(ED3)

The study has shown what the perceptions of the stakeholders believe that the knowledge and skill base to be. The following chapter will discuss and analyse these findings and link them to a set of fuzzy predictions which will show how these findings may be of interest to educational managers.

Chapter 5 - Discussion and Analysis

This section takes each of the themes of the research as outlined in the findings and expands the analysis utilising QSR NUD*IST as an analytical tool. The analysis focuses back to the research questions and examines the lived experience of the subjects.

In addition to the analysis of the data in terms of what are the perceptions of the stakeholders, an analysis of the interview techniques used will also form a major part of this discussion, as this will throw light on how the data was obtained and forms part of the study's contribution to knowledge.

Structure of the discussion and analysis

A useful way of structuring the discussion and analysis is found in Rolfe *et al* (2001). The structure is based around asking the three basic questions of What? So What? and Now What? The What? question relates to the thick description of the data which appears in the findings chapter, the So What? question is concerned with trying to understand what the subjects actually meant by the data they shared during the interviews and how this relates to the central focus of the study, the literature and the research questions. The Now What? question is considered in the conclusion and recommendations which is where the significant contribution to the knowledge in educational management emerges.

'So what' do the findings mean?

The subjects interviewed were very forthcoming in articulating their perspectives around what they thought needed to be included in the education of mental health nurses. A clear set of knowledge, skills and attributes emerged from the interviews which was fairly well agreed upon across stakeholder groups, and which was consistent with previous research studies evaluating Project 2000 in general and mental health nurse education in particular. There were particular similarities found with the themes cited in the research done by the English National Board for Nursing Midwifery and Health Visiting (1996).

ENB Themes	Findings from Case Study
Working with others - inter-professional, multi-agency and multi-disciplinary team working skills.	All subjects interviewed were strongly of the opinion that there was a need to work across different disciplines and that this required collaboration skills.
Clinical practice - management and leadership skills, skills of developing self and others	Although different stakeholder groups had slightly different emphases with regard to practice, management and leadership skills, all were in agreement that they were vital.
Learning formats – Interpersonal communication and counselling skills, group-work skills, knowledge of basic anatomy and physiology, particularly in relation to neuro-pharmacology and neuro-psychiatry.	The knowledge base required, as stated by the interview subjects differed only slightly, in that there was more of an emphasis in the case study on mental illness and its manifestations than on the anatomy and physiology relating to neuro-psychiatry.
User enablement and empowerment – recognition of user empowerment and advocacy as fundamental to the relationship between user and nurse.	This message seems to have been very clearly received, understood and embraced by all of the stakeholders – user and carer empowerment was seen in the case study as of paramount importance at all levels.
Responding to the market and service priorities – skills relevant to the care of people with severe and enduring mental illness.	Although this was not directly referred to by all stakeholder groups in the case study, it was taken for granted that the skills of looking after people with severe and enduring mental illness would be included in the course.
Values – user empowerment, confidentiality, open and honest relationships with users and carers based on mutual trust and respect.	All of these values were articulated in the case study and agreed by all stakeholder groups. One value, or attribute which came out strongly in the case study but was not included in the ENB study was the importance of being motivated.
Impact of new models of care – risk assessment and management, assessment skills in dependency and self-harm.	Risk assessment and the subsequent management of risk was again cited by all stakeholder groups.

On a more local level, the report *No More Square Pegs in Round Holes*, carried out by the West Yorkshire Education and Training Consortium

(2000) produced the following three themes, described in the report as the three pillars of mental health.

- Working with professionals and teams,
- Working with service users and their carers,
- Working within the service

Again, the case study found that all of these themes were regarded as being of high importance to all of the stakeholder groups interviewed. The data from the case study could fairly simply have been organised under these three themes.

The findings of the study appeared to be consistent with the literature, both at a national and at a local level, with very little new material emerging in terms of what was expected of the qualified mental health nurse. This was true for knowledge and for attributes, or qualities.

A major variation found, however, was in the level of skills talked about by the interview subjects in comparison with the literature. From the most senior policy makers, to the most junior nursing students, all were of the strong opinion that what was required was a set of very simple communication and interpersonal skills sets. All were clear that they were not looking for sophisticated counselling skills or therapeutic interventions, but a much simpler set of skills entirely.

The phrase *'it's not rocket science'* was a widely used analogy by the interview subjects to describe this phenomenon. The kinds of skills they were talking about were simple conversational skills, greeting people, holding a normal conversation, displaying warmth, having some kind of interaction which left the patient feeling better after it.

The view was expressed, that put at the simplest level patients wanted to feel that staff were being helpful and that they felt better as a result of interacting with them.

'the extent to which, when somebody goes into hospital, or when someone engages in one of the specialist mental health services, essentially what

they want is something that is helpful, from a nurse, from a doctor, so at the end of the experience that they can say I feel better as a consequence of my engagement with you.’ (SD1)

Multiple realities?

It was, however, felt by the interview subjects that their views on this issue would probably not be shared by others. Given that the most senior people involved in policy making and commissioning and structuring courses usually meet in either a formal meeting setting or whilst attending a conference, there was a general feeling that they would be embarrassed to share these views at such an event. Papers delivered at such conferences suffer the same fate, and appear to require to be wrapped up in much jargon and over-elaboration that the simple meaning tends to get lost.

It would appear that the idea that what is most important within the preparation of mental health nurse education is a set of very simple basic communication skills, and that this has become a really well kept secret. Everyone seems to know about it but no-one is willing to speak about it in public at least.

Of course there are situational constraints, for example in a conference, where participants may not wish to raise these issues for any number of reasons. What was apparent, however, was that the ‘big picture’ issues *were* being raised by these stakeholders, which seems to imply that they were not averse to raising issues in this situation, but that they were not willing to raise the ‘small picture issues’.

Similarly, in meetings, specifically designed for the purpose of exchanging information, it was once again ‘big picture’ issues that were being raised. There may well be a tacit understanding amongst stakeholders of the importance of basic communication, but this was never discussed when decisions were being made as to the content of courses.

It might be postulated that this was an unsurprising finding which might be attributed to the notion of multiple realities as postulated by Schutz and Luckmann (1974). They talk about how in the one-to-one interaction which they term the I-thou relationship one grasps the conscious processes of the other in a step-by-step manner by means of observing and analysing verbal and non-verbal behaviour. In a situation where more than one person is present, one can attend to each individual in turn thus experiencing the I-thou relationship, but attention can consciously be shifted to what Schutz and Luckmann term the I-they relationship. This would entail looking for meaning within the context of the interaction between the parties present.

The meaning of the interaction then could be viewed from either the I-thou or the I-they perspective and may therefore result in different types of information being shared. Following these ideas through, each individual within a collection of contemporaries may then be experiencing reality from more than one perspective either shifting between perspectives rapidly or perhaps even experiencing them simultaneously. Schutz and Luckmann appear to be arguing that communication in this context may well be situation dependent.

Similarly Heron (1987) describes perception as a cultural phenomenon. He argues that we learn to see things in terms of the concepts and categories that come with the mastery of language. Heron describes social practices as being functional, in that they are concerned with maintaining social effectiveness and cohesion. Heron does, however, begin to counter this argument by describing how an individual may construe actively while looking, to rethink the world in the very act of seeing it and to restructure the belief system that is built into the process of perceiving.

Although multiple realities may begin to explain the different kinds of information being shared by individuals in different contexts, it remains that there is still the element of choice and that the individuals interviewed were exercising that choice. It may not be surprising that the perceptions of the stakeholders are situation dependent, but it is perhaps surprising that given

the context and the choices made by the stakeholders, they chose to perceive in they way they did and to share the information that they did.

For the curriculum planner, this makes the management of the perspectives of the stakeholders problematic as all stakeholders cited the need to be aware of the needs of the other stakeholders and as vital to their being able to fulfill their roles. It would appear that there is a widely held perception amongst stakeholders that they are aware of the needs of the other stakeholders, but the needs expressed publicly are not necessarily the needs which are actually felt.

Political Perspective

What are the needs of the Health Service today in relation to mental health nursing and to what extent does the current provision of nurse education meet those needs?

Summarising the findings from the interviews in relation to this question, the needs of the Health Service today in relation to mental health nursing are to have nurses who have a sound knowledge base in relation to mental health and illness. They need to be able to work in a collaborative way in a multi-disciplinary team including the patient and their relatives and carers within that team. They need to be confident and well motivated and able to manage difficult situations. They need to be able to communicate openly, honestly and at a very basic interactive level with patients and carers.

Although there is a need for a small core of more highly qualified staff to have more sophisticated communication, counselling and therapeutic skills, it was not felt that this was a need for the majority of qualified nurses.

***'to me you train for a purpose but that purpose is not a speciality.'*(SD2)**

Fitness - How are the concepts of fitness for purpose, practice and award understood and to what extent are they understood differently by the different stakeholders?

Summarising the findings from the interviews on this question – as was found in the review of the literature, fitness for practice and award are well understood, and relate to the students meeting outcomes specified by the Statutory Body (now the Nursing and Midwifery Council) and the university respectively. Fitness for purpose was variously described, mainly in metaphors, the two most common being hitting the floor running, and having a blanket of skills.

‘They need to be able to hit the floor running’(SD4)

‘ the type of, like, baseline that people are meant to come

out with a kind of blanket of skills.’(SD5)

The meanings attached to these metaphors were that it was anticipated that when nurses completed their training they were expected to be able to be ready to perform as qualified nurses without needing much of a transitional period of supervision. They were also expected to have the basic skills necessary to perform as a qualified nurse in this way, regardless of the area they ended up working in, as the skills deemed necessary were basic communication skills.

Management of Fitness

Are the perceptions of all the stakeholders similar and therefore able to be reconciled, or are they so dissimilar that it would be virtually impossible to create a provision, which meets all the identified needs?

Summarising the findings from the interviews – There was a surprisingly high degree of agreement amongst stakeholders as to how they perceived fitness for purpose, practice and award, but, apart from one exception in one of the

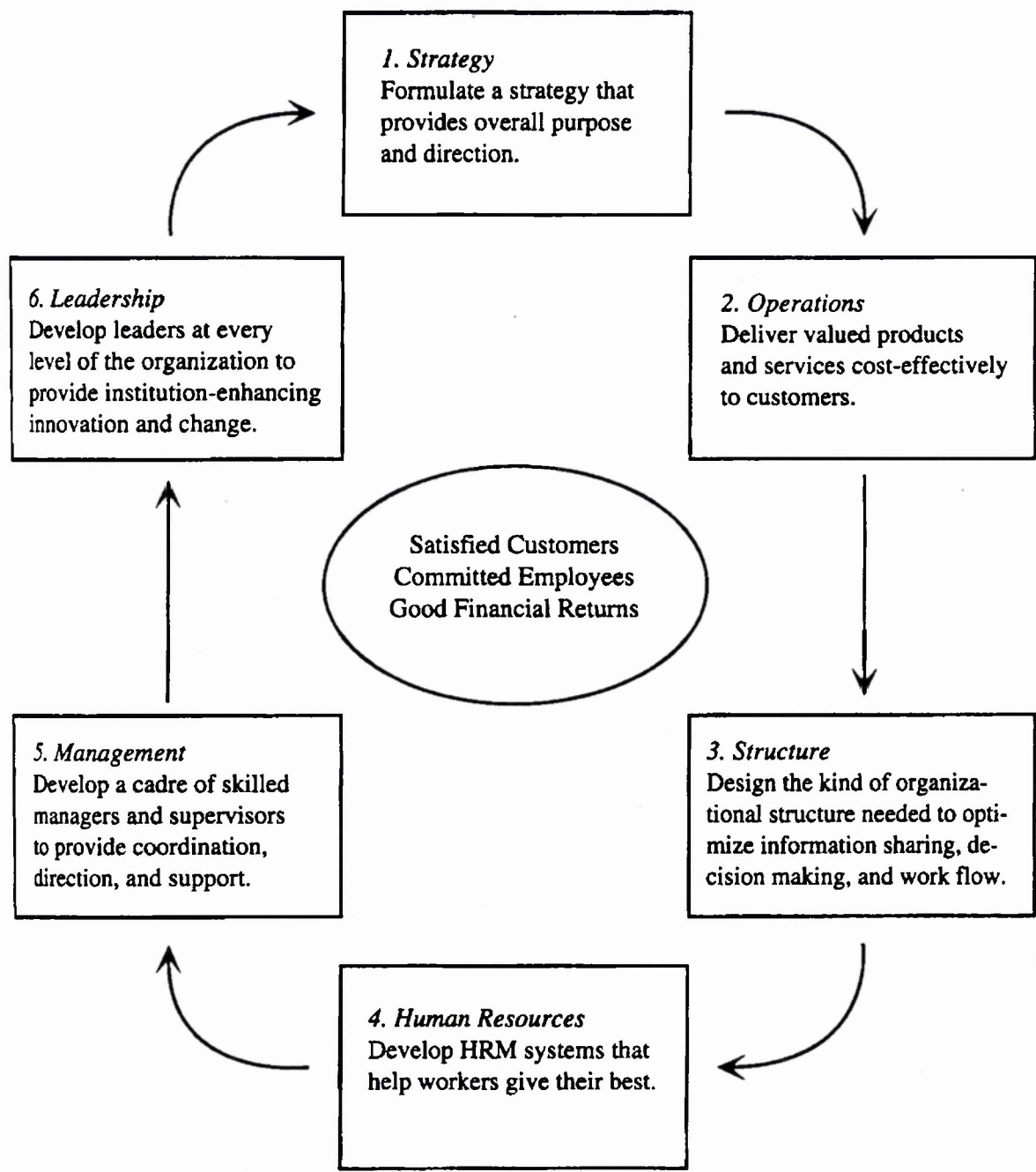
education provider stakeholder group, an almost complete unawareness that this was indeed the case.

'We are all working for the same purpose. At the end of the day we all want the same things!'(ED13)

In order to examine how this phenomenon can be managed, two models were examined, which proved to be useful.

According to the theory proposed by Egan (1993), satisfied customers, committed employees and good financial returns are central to the success of managing for excellence. Egan's model argues a cycle of six management tasks through strategy, operations, structure, human resources, management and leadership. A diagram of the model follows;

Figure 2.1. Model A: The Pursuit of Excellence Task Cycle.



The application of this model to the management of the perception of stakeholders for education managers who are tasked with producing courses for mental health nurses could be as follows:

Strategy – The overall purpose and direction for the educational manager is to provide educational activities which meet the real needs of the stakeholders. Any courses provided need to deliver the outcomes desired by the stakeholders.

Operations – The educational activities provided must be valued by the stakeholders, and delivered in a cost effective way through the contracting mechanisms currently in place.

Structure – The structure of the organisation needs to be capable of finding out what is needed, make swift decisions about what to deliver, when and how.

Human resources - The human resources of the organisation need to match the kinds of educational activities being delivered. There should be people capable of delivering the right education at the right time, for the right price, and in the way which meets the expectations and needs of the customers. Staff need also to be continually developing knowledge and skills based on what is required.

Management – Skilled managers need to be able to work with professional staff, and within a university environment which is normally managed in a collegiate way.

Leadership – Skilled leaders need to be developed at all levels in the organisation.

There are several difficulties with the application of the model. Firstly, the entire model is predicated upon the educational organisation having a detailed knowledge of the needs of the stakeholders. This is a requirement at all stages of the model from the formation of strategy through deciding what educational products to deliver, to developing the skills and knowledge of staff. If the information about the needs of the stakeholders is not accurate, the entire organisation may form, grow and develop in completely the wrong direction. If the articulated needs of the stakeholders are not the needs that they truly hold, as was found in the interviews, the educational organisation may grow and develop into an organisation that does not really meet the needs of the stakeholders.

For example, in the mid 1990s in Northland, there was a perceived need from the nurse managers, which was requested through the formal commissioning channels, to develop nurse therapists. A substantial sum of money was spent on sending 4 staff on a full time course to gain the nurse therapist qualification, but on their return a year later, it was determined that there was only sufficient demand for one practising nurse therapist. The other three resumed the same duties they had prior to their studies. Whilst it was argued that the training received would enhance their practice, the investment in time and finance could be questioned.

The second model utilised was that of Sanderson (1993), who looked at management issues in local government and proposed a framework for public service evaluation, and the delivery of valued outputs for stakeholders.

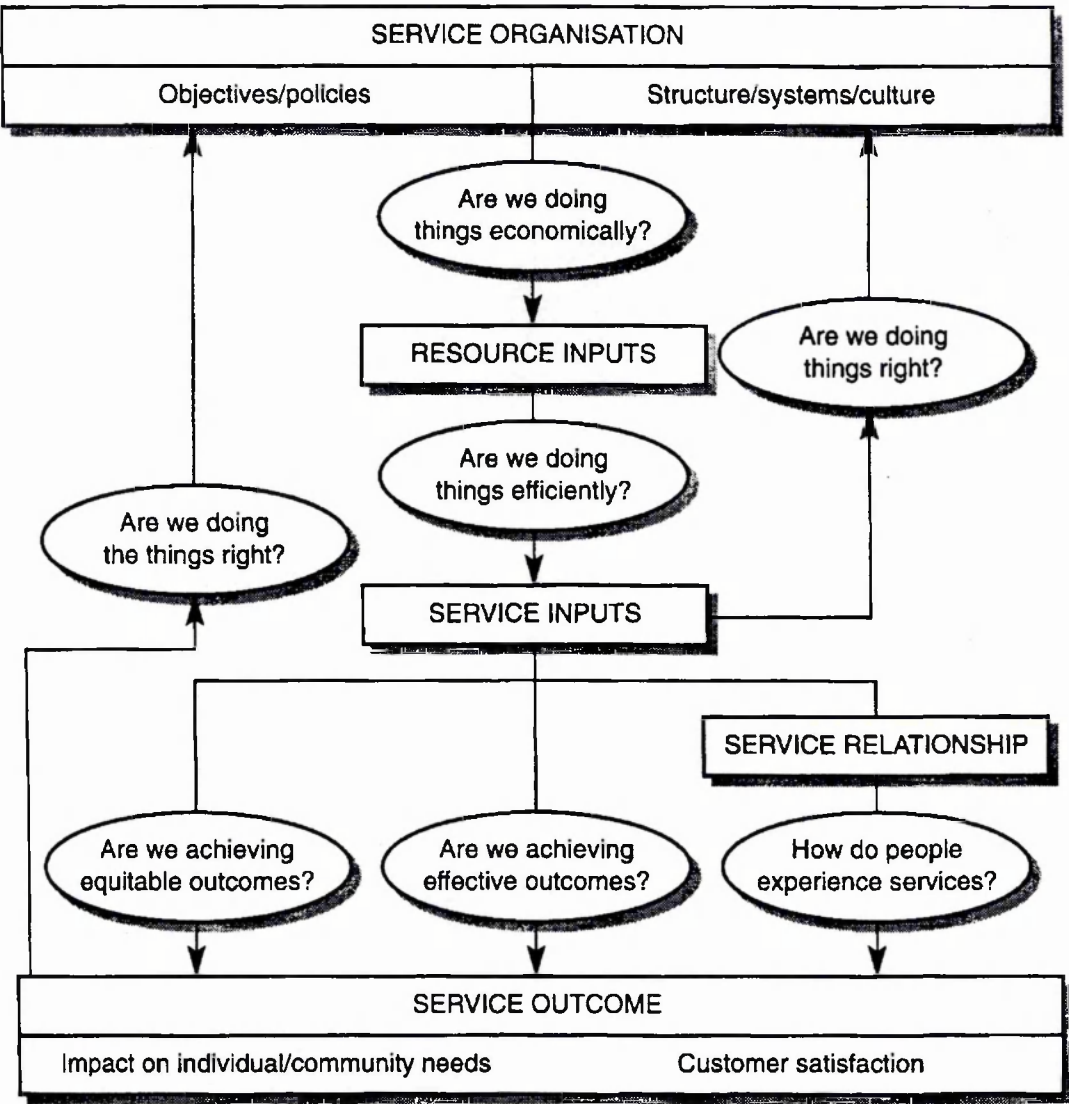


Figure 4.4 A framework for public service evaluation
Source: Sanderson, 1993.

The outcomes of this model include both customer satisfaction and the production of an impact upon individual/community needs. At various stages in the model, questions are asked about the service being delivered. One particularly useful question posed is ‘How do people experience services?’ Applying this model to the management of the perceptions of the stakeholders in mental health nursing could be useful, but only if this key question is clearly answered. If, as appears to happen, from the interview findings, the

real needs are not expressed, the danger of the organisation believing that it is growing, developing and producing valued services when it is not doing so may still occur.

As noted in the review of the literature, the meetings to discuss the needs of the stakeholders are very formal contract monitoring meetings. Upon studying the minutes of those meetings, it can clearly be seen that a pattern emerges whereby discussion is centred around the meeting of outcomes. There is neither detailed discussion here about what those outcomes were nor discussion about the detail of what the outcomes should be for the coming year. What is discussed is mainly to do with quantifiable targets such as how many academic credits have been delivered or how many hours of teaching have been delivered under the contract. What has previously been agreed are 'floors and ceilings', minimum and maximum teaching or academic credits to be delivered. The discussion tends to range around the education provider showing how they are above the 'floor' and approaching the 'ceiling' thereby showing that value for money has been achieved under the contract.

This formal contracting meeting scenario is certainly not where open discussion about the needs of the stakeholders occurs. It is actually quite difficult to determine where this type of dialogue actually happens at all. Some clues can be found in the interview with the Dean of School who was very aware of the need to find out where mental health is going and to ensure that the university was delivering education which matched that direction.

'in our contract review, one of the issues that came up was we are considered to be innovative, dynamic, but there were two areas that they thought that we were not thinking ahead, one of those areas was mental health. And their view was, rightly or wrongly that what we provided was what is, and wasn't really tuned in properly to where services were going.'(ED13)

In order to find out the answer to where services were going, several people were consulted by the Dean. These were identified as not necessarily being the most senior managers in each trust, but the people who were described as the 'culture carriers'. It was unclear as to how the identification of these individuals was made other than in a fairly opportunistic way, by one person who was consulted recommending another.

' My problem was I didn't know who to talk to. I know that there are a lot of managers, I know who has authority and responsibility, but I didn't know at the time who were the culture carriers, the decision-makers the movers the drivers, because they were going to be the ones who were seeing it through. '(ED13)

' So what I did was to work out who those people were and I did a fair bit of networking over dinner over lunch at conferences, and people would tell me how they honestly saw the university. '(ED13)

A very clear idea then formed that the university needed to fit into the world of the stakeholders in order that the university became a part of the world of the stakeholders.

'it seemed to me that we needed to develop something that was a strategic map of where we fitted in other people's worlds. We needed to then work out how we behave and performed in order that they knew that we were on that map and that what we did fitted into that map in a way that was helpful. Therefore as they re-constructed their map, we were part of it. '(ED13)

The argument put forward in the negotiation was, that as the university had an existing contract to provide education, it made little sense to look elsewhere

for specific education and training, what made sense was to ensure that the university provided the education that was needed.

‘ I have a big contract from the NHS to provide the education that you want. Now you can go somewhere else and buy it, but why do that when you have already got the money with me? But I'm sitting here saying, what do you want me to do with this money? It is an open book. The first thing that happened was XX said well look I want a new consultant in mental health.’(ED13)

The emphasis here seemed to have shifted away from the education and training that could be provided by the university, to how can the staffing and the skill mix of the trust be improved.

The decision was then made to have what was termed a whole systems event to endeavour to determine the needs of the stakeholders in mental health

‘what we're doing is we are going to have a whole system's event. And what we will be doing at that event is that we will be involving all of the people involved in mental health education here, whatever their professional background. And it will involve stakeholders from all of the external organisations. And what they will do is first of all they will identify what sort of processes, from the very point of somebody who had mental health problem going along and seeing their GP, all the way through the process.’(ED13)

This in terms of Egan’s model was the formulation of strategy based on a sound knowledge of the needs of the stakeholders, and would appear to make perfect sense.

The main problem with this way forward is that the ‘whole systems event ‘ planned was going to be a high prestige event with all the culture carriers from the service delivery stakeholder groups being invited and the most able and impressive academics in mental health from the university. The

likelihood that similar, very basic educational needs will be articulated at such a prestigious event is very small. This has now become a political event intended for the university to demonstrate to the service delivery stakeholders how well set up it is to meet their needs, and for the service delivery stakeholders to demonstrate how keen they are to ensure that their staff are as up to date as possible and keen to collaborate with the university.

Why did Stakeholders Share their Perceptions?

The question remains then, why the interview subjects felt able to share their perceptions in an interview scenario and are not apparently willing to do this in contracting meetings, whole systems events or even on a one-to-one with the senior staff of the university. Part of the answer to this has, of course, to do with the informality of the interview setting, and the detachment of the interviewer from the operational realities of the contracting process. Another part of the answer may have been in the way the interviews were structured.

The interview method specified in the pilot study was utilised consistently throughout the full study. Rapport was established and maintained with the subjects, a broad introduction to the topic being studied was given, and the subjects then progressively encouraged to share relevant data by use of meta model, challenges to deletions, generalisations and distortions as this appeared relevant.

As in the pilot study, the ratio of words used by the interviewer to the subjects averaged out at around 20% interviewer to 80% interview subject. One interview which stands out as being particularly one sided was the interview with the Dean of School which showed a balance of 4% interviewer input to 96% interview subject. Very few interventions were needed in this particular interview to encourage the subject to discuss relevant information. The idea of the interviews was to encourage the subjects to talk freely about the subject, with as little intervention from the interviewer as possible. The percentages quoted would appear to imply that a fairly high success rate was achieved here.

A phenomenon noticed during all of the interviews was that once rapport was established and the explanation was given as to the kind of information I was looking for, the interview subjects began talking very freely and their demeanour resembled a light trance state. Their breathing slowed down, they settled back into their chairs, their eyes took on a glazed-over appearance, and they continued to talk without appearing to be aware of either my presence or of the presence of the recording equipment. Although this phenomenon could not be captured in the transcript, I was able to observe this quite closely as I was aware that I could return to the content of the interview when the recording was played back for the purposes of transcription. I believe that this degree of being at ease with the interview and the interviewer may have been an important factor in the quality of information that was shared during the interviews. In the therapeutic context, this type of light trance state is often utilized to help clients relax and to begin to share their deeper feelings with the therapist. No claim is being made here that either during therapy sessions or in the interviews, whilst in a trance-like state, clients or respondents give more authentic information. However, what is important and is being claimed, is that the information thus gathered, is substantially different, and whilst it may not be more authentic, it certainly is more detailed and basic, and therefore of potential value to curriculum planners.

The table produced on page 60 has been modified here to include examples from the transcripts of how the deletions, generalisations and distortions used by the interview subjects were challenged by the interviewer. Not all deletions, generalisations and distortions were challenged as this would have interrupted the flow of the interview subjects' thoughts, the challenges were made when it was judged by the interviewer that more information on that particular issue would be relevant to the study.

Linguistic Pattern	Example	Challenge	Effect
Deletions			
Unspecified Verb	They should actually be able to demonstrate interventions with clients at the end of the branch	What kind of interventions? (demonstrating interventions being unspecified)	Subject gave very specific information 'interventions like giving support doing assessments and then several types of interventions such as relaxation therapy, and management, and any other additional kind of treatment or therapy that crops up.'

Linguistic Pattern	Example	Challenge	Effect
Deletions			
Lack of Referential Index	I wonder if you could say the same for <u>other professions</u> . I doubt it.	what do you mean by the other professions do you mean solicitors, dentists that kind of thing?	Subject clarified what it was they really meant. 'yes I mean things like professions like teaching, the law, that kind of thing.'
	<u>you</u> really need to keep your head down on the desk and really work at it to find out what is going to produce the benefit that you want.	By 'you', do you mean all members of the collaborative?	Again subject clarified what they meant precisely
Comparative Deletion	<u>more</u> of the tutors should spend much <u>more</u> <u>time</u> in the clinical areas	How much are they there now? (to establish the position that is being compared to)	This gave the subject the opportunity to think through more on precisely they wanted.

Linguistic Pattern	Example	Challenge	Effect
Deletions (cont)			
Simple Deletion	There are to my mind challenges to nursing itself	what kind of challenges?	More precise information was given. 'professions are under attack, from the government point of view. The medical profession are under serious attack, they have had a lot of bad press recently as well, but nursing stands next to medicine as well.' This was further probed as to the precise nature of the attacks.
Presuppositions	I don't think we are preparing nurses properly. I think there are huge gaps in the service where nobody is skilled to deliver.	What kinds of gaps? (fairly wide ranging generalisation showing 3 presuppositions – not preparing nurses properly, gaps and lack of skills)	Much more precise information was then shared.

Linguistic Pattern	Example	Challenge	Effect
Generalisations			
Modal Operators of possibility	We <u>can't</u> just sit back on our laurels and get on with the job.	how might you get to that? (underlying question was what would happen if you did?)	Instead of talking about what could not be done, subject went on to give information about what could be done, which was much more relevant data for the project
Modal Operators of necessity	we must ensure that at the end of three years the practitioner can achieve all of those outcomes.	so how would you find that out? (what would happen if you didn't?)	Very precise information was then given on perception of what the outcomes should be

Linguistic Pattern	Example	Challenge	Effect
Generalisations (cont)			
Universal Quantifiers	When we used to have the nurses, they could do X, Y, or Z.	What kind of X, Y and Z's do you think they are talking about?	The subject clearly specified what was meant. 'I think they mean fairly routine stuff of managing difficult people, taking charge of individuals, getting competent to run the ward from the first day.'
Distortions			
Nominalisations	but I am thinking more, rather about interpersonal competence required in a range of typical and specific interaction contexts that are characteristic of the normal practice of the mental health nurse.	for example? (To be competent in an interpersonal context is a verb – the idea here was to encourage the interview subject to expand upon how this competence would be demonstrated)	Specific examples of what was meant were then discussed.

Linguistic PatternDistortions (cont)	Example	Challenge	Effect
Cause and Effect	we don't know what the new statutory body will be and whether they will have different ideas about preregistration nurse education, but we feel that as far as possible we use a very consultative process.	what would the difference be? (as it was unclear how the cause and effect were linked)	Specific information on the subjects perceptions about what they would wish to happen, and how that compared with their expectations were shared
Mind Reading	There are many things that medicine got wrong. their arrogance their patronising, they only think that trials are the way to research	Chance to challenge this was missed, what could have been said at this point was 'how do you know they think that?' (subject was talking freely and it was judged better at that point not to interrupt the flow)	

Linguistic Pattern	Example	Challenge	Effect
Distortions (cont)			
Complex Equivalence	I think by the time we had written it, everybody was working together	so what kinds of things helped?	Specific information was given on what working together meant.
Lost Performative	So that would be sort of summarising the sort of thing I mean but Obviously its very loose	so take one of them then – say the admission Process. What precisely would you expect the nurse to know to do?	Valuable very specific data was then given about what was perceived to be really important outcomes.

What can clearly be seen from the above table is that on each occasion where the interviewer challenged a deletion, generalisation or distortion, more information was given by the subject. The information given was, in each case, more specifically focused to describe the perceptions of the subject and therefore directly relevant to the study.

A pattern emerged which showed that challenges to deletions resulted in more precise information being given in relation to the issue being discussed. This assisted in clarifying precisely what the interview subject meant by the words used.

Challenges to generalisations also led to more precise information. However, the nature of the clarifications given here were in relation to moving away from sweeping statements to more precisely what the interview subject's perceptions really were.

Challenges to distortions also yielded more precise information and appeared to have the effect of helping the interview subjects understand more clearly what they actually meant by what they said.

'Yes, now I know what I meant to say'

'There's more to this than I first thought'

The meta model questioning techniques not only helped the interviewer to uncover the relevant data, but also helped the interview subjects to clarify in their own minds, what it was that they were talking about. This, again, is something which is a useful technique which has been borrowed from therapeutic interventions.

Chapter 6 - Conclusions and Recommendations

This chapter sets out what conclusions can usefully be drawn from the data, how those conclusions fit into the literature and how they can throw light on the research questions. Attention has already been given in the findings chapter, to issues of generalisability and to issues of sensitivity about how the findings and conclusions will be shared with the major stakeholders. Any claims made for the data will be directly attributed to data received, but will, for reasons of confidentiality, not be attributable to any individual interview subject.

The main research questions that have been examined are as follows:

- What do the students believe their knowledge and skill base should be at the end of the course? Which knowledge and skills do they believe they are deficient in, and what areas included in the course appear to serve no useful purpose?
- What do stakeholders believe the knowledge and skill base of student mental health nurses should be at the end of the course? Which knowledge and skills do they believe the students to be deficient in, and what areas included in the course appear to them to serve no useful purpose?
- What are the needs of the Health Service today in relation to mental health nursing and to what extent does the current provision of nurse education meet those needs?
- How are the concepts of fitness for purpose, practice and award understood and to what extent are they understood differently by the different stakeholders?
- Are the perceptions of all the stakeholders similar and therefore able to be reconciled, or are they so dissimilar that it would be virtually impossible to create a provision which meets all the identified needs?

The discussion in relation to the different stakeholder groups has, however, mainly been grouped together, with any differences in perception being highlighted where they exist. This is to avoid unnecessary repetition that might have resulted from the unexpected similarities in perceptions across stakeholder groups.

At the end of this chapter, the findings have been redrafted in the format of 'fuzzy generalisations' which may assist in their application to educational practice.

The knowledge base

Knowledge relating to the needs of service users and carers.

Knowledge about the needs of users and carers was seen as being vital, but this appeared not to relate to a detailed knowledge of theories of human needs and motivation, rather it seemed to consist of very basic information about understanding human needs and being able to respond to them.

Knowledge about mental health and illness.

The knowledge about mental health and illness that was being talked about was also of a very basic nature. What was being talked about was a knowledge of what constitutes mental health, and when this breaks down, how it can then manifest itself in mental illness. It was felt necessary to include what could be termed medical model type of knowledge in relation to the aetiology, signs and symptoms and treatment options, including a basic understanding of the drugs used in the treatment of mental illnesses. All of the stakeholders interviewed were confident that this was currently, and had, in fact always been well covered in the curriculum.

Knowledge about research

The knowledge about research related to an understanding and appreciation of research methods, in order that research could be read, understood and evaluated. This was seen as being a means to an end, which was the utilisation of research to inform practice. There was not an expectation that the knowledge about research included in the curriculum would be sufficient

for the students to conduct empirical research. This knowledge about research again was of a very basic nature.

In terms of the knowledge element, limiting the knowledge about research to basic understanding and appreciation seems to be going in completely the opposite direction to the intentions of Project 2000, particularly as reported by Price Waterhouse (1987), in the push for improvement in educational standards

‘the new programme should have academic standing as an advanced educational qualification with closer links between schools of nursing and academic institutions.’

This would seem to be arguing for more sophisticated and detailed theory and a higher level of academic knowledge, which could be related to both nursing attempting to gain more academic credibility as all of the courses move from the National Health Service into higher education and to nursing attempting to increase its claim to being a profession. The reality of the data collected, however, was that the knowledge which was being asked for by the service delivery stakeholders was not of this type, but much more simple and basic.

The findings in relation to the skills required were mainly in the areas of management and with communication.

Management of self, management of ‘the shift’ and management of patients and clients seemed to be regarded by those interviewed (other than by the students) as being fairly simple skills, but management of difficult situations was seen as a complex skill, requiring high level communication skills and was not expected of newly qualified nurses. Similarly, when the point was pursued, management of patients and clients and managing ‘the shift’ were not expected at the point of qualification. It was expected that these skills would develop after qualification and a period of experience.

The skills that were expected at the point of qualification were interactive skills and collaborative skills. Again as in the case of the knowledge

component, these skills were seen as being very basic standard, everyday skills, described in several interviews as ‘not rocket science’.

These findings tend to be in agreement with the greater part of the literature dealing with the views of users and carers which points to a perception that high quality of care is received when the nurses spend time with clients, listening, engaging in ordinary, everyday conversation showing empathy and demonstrating simple interactive skills. These simple interactive skills included listening to clients, showing respect for them as human beings and providing helpful explanations of their care. The provision of helpful explanations of care would, of course require the nurse to have an understanding of the care and treatment.

The picture of the nurse who would be ready to ‘hit the floor running’ on qualification would have the knowledge and skills as described. The picture is complete by adding the attributes of a confident, motivated team player.

When this is compared with the core skills talked about in the report published by the Sainsbury Centre for Mental Health (1997), which itself represented the culmination of much user and carer research, it can be seen that the knowledge, skills and attributes are very similar to those found in this study.

- General training in mental health
- Appropriate values and attitudes
- Appropriate communication skills to develop and maintain effective therapeutic relationships with clients
- Listening and questioning skills
- Written and verbal skills which contribute to inter-agency working

- Flexible approach
- Willingness to learn from others and to apply a problem-solving approach
- Knowledge of the needs of minority groups and black and ethnic minority cultures

With the exception of the knowledge of the needs of minority groups, which was not specifically discussed by stakeholders in the interviews, all of the issues above show strong similarities to the data gathered from the interviews. In terms of comparability, the findings of this study do show some fairly strong similarities with the literature, the differences being mainly around the level of detail and specificity. The recommendations of the Sainsbury Centre for Mental Health (1997) (SCMH) advocate appropriate communication skills, whilst this study was able to specify precisely what those skills were. Recommendations were also made by the SCMH about appropriate values and attitudes, whilst this study looks more specifically at what attributes were valued.

In comparing the results of this study with the later study by the Sainsbury Centre for Mental Health (2000), *The Capable Practitioner*, which does clearly specify in much more detail knowledge, skills, values and attitudes required of a mental health practitioner, there are very strong similarities with the findings of this study, as the following table shows;

Findings from <i>The Capable Practitioner</i>	Findings from this study
Knowledge of policy and legislation including Mental Health Act	Findings included a very similar set of policy and legislation which was required to be understood by nurses
Knowledge of mental health and mental health services, causation, incidence, prevalence description of disorders and the impact on individuals, families and communities.	Findings in this area were very similar, including knowledge about causation, incidence, prevalence description of disorders and the impact on individuals, families and communities.
Process of care – this section incorporated much information on effective partnerships with users and carers and with teams and external agencies.	Knowledge of the needs of users and carers was considered to be one vital knowledge component. Skills and attributes which facilitate effective collaboration were also considered to be vital for mental health nurses.
Skills of comprehensive assessment were included here, including the skills involved in risk assessment	Assessment skills and skills in risk assessment were considered by the stakeholders to be vital.

Findings from <i>The Capable Practitioner</i>	Findings from this study
Care Planning, co-ordination and review – this included the ability to effectively plan care and to document that care effectively	Assessment, planning, intervention and evaluation of care were considered by stakeholders interviewed to be basic nursing skills which had been systematically included within the nursing curriculum even prior to Project 2000. Effective written communication skills was not directly mentioned other than by education stakeholders, and then mainly in relation to the ability to write academic work.
Supervision, Professional Development and lifelong learning including self awareness of capabilities and limitations, the ability to reflect upon practice and to maintain and develop practice skills were the important capabilities listed under this section	This compares with self management, professional development and self awareness of skills and limitations which was considered to be vital by all stakeholders.
Clinical and Practice leadership included the use of evidence based practice and the skills of leading and motivating a team. Ensuring safety of staff and patients was also included under this section	Very similar findings here, in knowledge, skills and attributes section. Issues regarding management of risk and maintenance of safety were also included.
Interventions included basic nursing care and management of violent and potentially violent situations	Very similar findings included under several different headings of skills. It was these basic nursing skills which all subjects interviewed agreed were fundamental to nursing, but were well covered in the current course.

The Capable Practitioner, then, represents the most detailed and specific set of researched knowledge, skills and attitudes to date for mental health nursing, the findings of which were very similar to the findings of this project in this area.

When the literature was reviewed, what could be seen, other than what is contained in *The Capable Practitioner*, is that a similar pattern emerged of lack of specificity. Several studies talk about developing appropriate communication, interaction, management or counselling skills, but the

precise meanings of those terms were usually unclear. What seemed to be written about was what could be termed 'big picture issues'. What this study uncovered was much more information of the detail, or what could be termed 'small picture issues'.

When the local arrangements for managing the delivery of the curriculum is examined, by studying minutes of contract monitoring meetings, a similar phenomenon occurs. It would appear that 'big picture issues' are discussed freely, whilst there is a distinct lack of 'small picture issues' discussed, or at least recorded as being discussed.

The interesting question relating to this study was why this occurred. Why did those people who very clearly shared small picture issues with me, seem not to be doing this when meeting with other stakeholders? Some possible partial explanations for this could be that they were talking to me as a researcher, who was not directly involved with the delivery of the course, although they were aware of both my current position within the university and my past position where I did have a direct responsibility, prior to undertaking this study.

It may also have been related to the informality of the interviews, and the fact that the interview subjects were aware that the meeting was for the sole and specific purpose of exploring the research questions. Confidentiality was assured, in that no data would be able to be directly attributed to any individual, and that all interview subjects were offered the opportunity to see and edit the transcripts before analysis. To pursue those particular points of informality and confidentiality further, a sharp contrast emerged between the conditions of the research interview and the conditions which would normally prevail when stakeholders have the opportunity to discuss their perceptions.

The occasions in which stakeholders would normally meet to interact and to have their views aired on their perceptions of mental health nurse preparation, tend to be either in formal meetings or in fairly high powered conference type scenarios.

During formal meetings, which are minuted, care is taken to maintain a professional appearance. When the minutes of the meetings are studied, the tone is invariably friendly but very formal, notes of the meetings are produced in a very formal manner following a set agenda, of which the following is fairly typical;

1. Apologies for absence
2. Minutes of the last meeting
3. Matters Arising
4. Consortium Manager's Update
5. Dean's Update
6. Midwifery Review
7. Contract Monitoring
8. Major Contract Review
9. Research Project
10. Any Other Business
11. Date and time of next meeting

Under several of the headings, particularly the consortium manager's and the Dean's updates, there would be sub-headings relating to issues to be reported upon. All of the reporting of the meetings are handled very formally in that a member of administrative staff would be present at the meeting and would take shorthand notes of the meeting, the draft of the minutes would then go to the Chair of the meeting for approval before being distributed. The minutes themselves are regarded as confidential and only for circulation to those eligible to attend the meeting, although permission was obtained to use the minutes for this study, provided confidentiality was not breached.

Having studied the minutes for these meetings over a two year period, it is clear that a wide range of topics were discussed in relation to maintaining the quality of the educational input and the issue of achieving value for money from the contract between the university and the consortium. All of the issues discussed, however, appear to be 'big picture issues', in that from the side of the university, they related to issues such as major appointments made, research projects being undertaken, numbers of students recruited, retained or

awards conferred and issues regarding specific funding of particular professional groups.

From the consortium side of the discussion, the issues again were 'big picture' relating to important seminars, bursaries, commissioning intentions and future research funding.

There did not, at any time, appear to be any dialogue relating to the 'small picture' issues which relate to the perceptions of the stakeholders as to the precise detail what they actually want to be included in the education of mental health nursing (or indeed any other speciality). This phenomenon is interesting, particularly given that several of the members of these meetings were people who were subsequently interviewed for this study, and spoke very freely about the small picture issues with very little prompting.

The second main arena in which the different stakeholders meet tends to be in seminars and workshops, usually prestigious and held regionally. The format of these seminars and workshops tends to be that there will be eminent speakers giving papers on their particular areas of research, sharing their methodologies, findings and conclusions.

Usually there will be some form of workshop activity, where participants are divided into working groups to explore issues further, before feeding back to the main group. The seminars usually end with a plenary session and questions to the panel.

What was found from attending several of these seminars, was that, again it was almost exclusively 'big picture' issues which were discussed, for example training in Psycho Social Interventions, Cognitive Behaviour Therapy or counselling skills. Listening, in particular, to the feedback given to the main groups and the questions asked of the panels, there appeared to be a reluctance to say anything that appeared to be small picture. At no time did anyone volunteer small picture information; for example a perception that what mental health nurses needed most of all was very basic communication skills which was so prevalent in the interviews. It is possible this reluctance may be related to a desire to appear up-to-date, professional

and well informed, given the formal context of the workshops. Again this was made all the more curious, given that several of the people attending these workshops and seminars were the same people I interviewed for the study who were only too keen to share small picture issues with me during the interviews.

Naturalistic Generalisation

One way of looking at the findings of this study in terms of naturalistic generalisation might be to argue that big picture issues as described both in the literature and on those occasions when stakeholders meet, could be regarded as being common across the spectrum of mental health, but that the smaller picture detail as to precisely what those needs are may differ depending upon the mental health needs of the local population served and the types of services offered to those suffering from mental health problems.

What can be seen from the findings is that through utilising the interview methodology in this study, detailed information was gathered about the perceptions of the stakeholders as to what they believed constituted high quality mental health care. The information in the literature is, at best, less detailed and at worst quite vague. In order to manage the perceptions of the stakeholders, the much more precise, small picture type of information would prove to be much more useful in managing the curriculum. For example, a 'big picture' way of expressing a need could be as vague as saying that mental health nurses need more therapeutic skills. The 'small picture' detail as to the specific nature of the skills required that are understood by the term 'therapeutic skills' would enable curriculum planners to more closely match the educational provision to the perceived needs. Furthermore this would facilitate a dialogue between the educational provider and the stakeholder.

In terms of the research questions, the students and other stakeholders' views have been closely examined and described in this study of one university and its stakeholders.

The needs of the Health Service today in relation to mental health nursing are well described in the literature, but tend to be described in much more global and less simply defined and understood terms.

There seems to be a general satisfaction that the current provision of nurse education does meet those needs, but when the specifics are examined at a local level, there are some fundamental gaps in the knowledge, skills and personal attributes of mental health nurses.

The concepts of fitness for purpose, practice and award are well understood in a remarkably similar manner by the different stakeholders. The original idea upon which this study was based, emerged from a notion that stakeholders' perceptions might be very different to one another, perhaps even to the point of not being able to be reconciled.

The perceptions of all the stakeholders within this case study were very similar and therefore could be fairly simply reconciled if all the stakeholders were aware that they all were actually wanting the same things. The main difficulty, which seems to be getting in the way of managing this situation, is that there would appear to be a distinct difference in how information is shared in a formal and an informal context. The more formal the situation, the less precise the information shared. Information about the perceived needs of the stakeholders is gathered almost exclusively in formal situations, which results in mainly 'big picture' information being shared.

The findings in relation to the perceptions of the stakeholders seem to show many similarities to the findings in the literature. What this study does not argue, however, is that every location which provides education for mental health nurses will have precisely the same sets of perceptions of stakeholders, although, clearly, it could be argued that there will be some distinct similarities.

What the study will do is to provide some recommendations which will offer a framework to assist in the facilitation of the management of the stakeholders' perceptions.

In the report conducted by West Yorkshire Education and Training Consortium (2000) entitled *No More Square Pegs in Round Holes*, one of the principal findings was that

Good quality relationships between those involved in mental health care were seen by contributors as fundamental to maintaining and developing their ability to joint plan, work, educate , and train, and ultimately to realise meaningful change.

Good quality of relationships between all parties was also very clearly observed during the interviews, and through the study of local documentation for this study, but good quality relationships are not sufficient on their own, to ensure that handling the perceptions of the stakeholders is a managed process based upon dialogue which uncovers the 'small picture' needs.

However, one of the recommendations of the *No More Square Pegs in Round Holes* report was that the consortium should consider the establishment of a mental health advisor role. This mental health advisor role was seen as a developmental, possibly secondment based opportunity within the consortium, with the intention that this may further strengthen the links between partner organisations.

Although the details of the function of the proposed role were fairly sketchy, the idea was that the post holder would act as a knowledgeable, independent advisor across agencies and disciplines. They would keep abreast of the rapidly changing field of mental health and assist in the creation of appropriate educational and training responses to the rapidly changing environment, acting as a kind of liaison between the major stakeholders.

If the role of the mental health advisor were incorporated into a management model, the inherent difficulties with the model may be able to be overcome in the following ways

Adopting Egan's (1993) model:

- Strategy – The overall purpose and direction for the educational manager is to provide educational activities which meet the real needs of the stakeholders. Any courses provided should be capable of delivering the outcomes desired by the stakeholders. There is a clear role here for a mental health advisor to find out precisely what the real needs of the stakeholders are. It would not be appropriate for this to be done in a formal context, as it is fairly likely that the stakeholders would continue to talk only in ‘big picture’ terms, thus the needs would be left unstated. An informal approach which recreates the approach of the interviews for this project would be much more likely to yield the desired result.
- Operations – The educational activities provided must be valued by the stakeholders, and delivered in a cost effective way through the contracting mechanisms currently in place. The role here for the mental health advisor would be in taking a major part in the evaluation of the educational activities. All of the educational activities of the universities are subject to formal evaluation, internal monitoring and external monitoring by the Quality Assurance Agency, which results in a large amount of evaluation data which could be shared and fed back into the quality assurance loop. This again would only be as useful as the parties were open and honest in sharing this data. The more informal the setting, and the better the rapport between the parties, the more accurate and potentially useful the data would become.
- Structure – The structure of the organisation needs to be capable of finding out what is needed, make swift decisions about what to deliver, when and how. This again is completely dependent upon relevant and accurate data both in terms of what the major stakeholders need and want, and on the quality of the evaluation data. The role here for the mental health advisor, would be to ensure the relevancy and accuracy of that data by having an up to date knowledge of how the people involved in the production of that data are thinking and feeling.

- Human resources - The human resources of the organisation need to match the kinds of educational activities being delivered. There should be people capable of delivering the right education at the right time, for the right price, and in the way which meets the expectations and needs of the customers. Staff need also to be continually developing knowledge and skills based on what is required. Again this can only happen if education staff are aware of what knowledge and skills are required in the short, medium and longer term. The role for the mental health advisor is also key here.
- Management – Skilled managers need to be able to work with professional staff, and within a university environment which is normally managed in a collegiate way. The mental health advisor could contribute to this element by establishing credibility and being regarded as a partner in the management of the educational delivery.
- Leadership – Skilled leaders need to be developed at all levels in the organisation. If the mental health advisor was regarded as a partner in the management of the educational activity, and a bona fide member of the team, leaders from all levels of the organisation would be able to liaise with the advisor, ensuring that the leadership being provided, was leadership in a useful and up to date direction.

The establishment of the mental health advisor role could potentially provide the key to overcoming the difficulties with the application of the model. As previously stated, the entire model is predicated upon the educational organisation having a detailed knowledge of the needs of the stakeholders. This is a requirement at all stages of the model from the formation of strategy through deciding what educational products to deliver, to developing the skills and knowledge of staff. The input of the mental health advisor would ensure that this detailed knowledge was shared, and that the educational organisation could then form, grow and develop in completely the right direction into an organisation that does really meet the needs of the stakeholders.

The establishment of the role of the mental health advisor would greatly assist in obtaining an accurate answer to the key question posed in the management model of Sanderson (1993) which asks 'How do people experience services?'

In order to effectively carry out the role of the mental health advisor, the conditions of the research interviews for this study would need to be reproduced as closely as possible. This, in addition to endeavouring to maintain informality, would mean learning to utilise rapport skills techniques and meta model questioning techniques as described in this study. The techniques, themselves, however, need to be further researched to determine their usefulness.

Contribution to Knowledge

The contribution to knowledge from this study in terms of educational management, other than application to the specific local context, stems less from the content of the data gathered and more from the process utilised to gather that data.

It is of particular note that in the case studied and in the general educational management context there is not normally a distinction made between 'big picture' and 'little picture' information and issues. This, I believe represents a new way of theorising about educational management.

Several possible applications of that knowledge could be as follows;

Specific Local Applications

Examination of what is.

In the location chosen for the case study, all of the subjects interviewed will receive a copy of the complete study as they requested. A summary of the findings, conclusions and recommendations will be shared with the other key stakeholders, which will assist them in the future planning of the mental health nurse educational delivery locally.

The data here, in terms of what the perceptions of the stakeholders are in relation to fitness for purpose, will be directly relevant to the local area and represents an accurate thick description of the views of all of the stakeholder groups in the local area, with an analysis of that data which is then woven into the literature. The data, in the amount of detail available in this study certainly contributes to local knowledge about the local perception of the stakeholders and is not available elsewhere.

Examination of what may be.

The data and the analysis can also be used, in particular, by the university locally, to supplement the evaluation data for the pilot programme running. It will also be useful in contributing to a wider agenda of developing a strategy for mental health education in a broader context, as it gives a precise and accurate thick description of the perceptions of the stakeholders in this context also. This occurred principally because the interview subjects did not restrict themselves to talking only about the initial preparation of mental health nurses, but their perceptions in relation to post registration education were also shared.

Examination of what could be.

What appeared to be unusual in this case study was the apparently excellent relationships between all of the stakeholders. The relationships seemed to be well founded in mutual trust and respect, each stakeholder group being fully aware of the need to collaborate with all of the other stakeholders locally.

There was, however, one problem which emerged, which related to the perceptions, particularly amongst educational stakeholders, as to their perception of their competitors. This is well illustrated in the example whereby a need has been identified at a regional level for the delivery of a particular education programme.

The process for commissioning the new programme consists of the confederation (formerly the consortium) asking for competitive bids to deliver the programme. Each of the universities in the region then go into overdrive to produce the most attractive and cost effective bid. The contract

is then awarded to the 'best' bid. This is a standard procedure throughout the country. What tends **not** to happen then, is collaboration between the universities to determine whether a joint bid from two or more universities might produce a better and more cost effective solution, so intense is the spirit of competition. This may well need to be re-thought, there is scope here for further research at a national level to determine whether collaboration between educational providers might better meet the needs of all stakeholders.

Application to the wider context

In terms of the specific perceptions of the stakeholders in the case studied, there may well be similarities, given the typicality of the case studied, the extent to which there are similarities could be determined utilising findings in relation to the wider applications of this study, particularly in the methodology for gathering information.

The study examined the management of the perceptions of the stakeholders, for which, a knowledge of how the stakeholders perceived the issues and understood their world was absolutely vital. No claim is made here that absolute truth or ontological objectivity was discovered, or indeed exists, but only that the world of each of the stakeholders has been thickly described in their own words, and from their own point of view.

When two possible models of management were chosen for their potential applicability to mental health nurse education, viz. those of Egan (1993) and Sanderson (1993), it became apparent that each of these models, if followed, could be potentially very useful ways to look at managing the delivery of educational programmes. However, it was also apparent that they could potentially also lead to an educational organisation growing, developing and producing educational activities which were not in keeping with the real needs of the stakeholders, but from an erroneous notion as to what those real needs were. The idea, however, of strategy needing to be based upon accurate information about the needs and wishes of stakeholders or customers is a fundamental notion to whatever model of management is

used, and is therefore not limited to the two models chosen, but potentially much more widely applicable.

The idea of having a mental health advisor as previously described could be a really useful development here, although the title and role might need to be revised to reflect the idea of information gathering and liaison in addition to advice. The key notion would be that the individual in this role would need to maintain a balance of objectivity, collaboration and credibility with all of the stakeholders.

The findings in relation to how the data was obtained would be really useful here. The advisor would need to utilise the skills of rapport and the meta model questioning techniques to get to the information about the perceptions of the stakeholders. In short, the interview methodology as described in this study should be replicated by the advisor. This would lead to the university being more aware of the real needs of the stakeholders and therefore able to utilise whichever model of management they chose, to design a strategy and to develop an organisation which met the needs of the stakeholders.

Similarly, it would not be too difficult to apply the ideas of an advisor utilising the rapport and questioning skills to wider areas of educational provision or indeed more generally to any service industry.

What this study has clearly shown is that techniques borrowed from therapeutic interventions in a mental health context which were originally designed to firstly make the client feel comfortable, and then as swiftly as possible to get underneath the surface structure of what they were saying about their problems, to the deeper structure of what they thought and felt, could be useful in other contexts. The particular context in which this could be a useful contribution to the knowledge is in the research interview itself.

I would argue that the main goals of therapy are to help the client to feel comfortable enough to share information with the therapist about how they are experiencing their world and their problems. The client then is able to be facilitated through a process in which they can accurately uncover the deeper structure of how these problems and difficulties have arisen, with the

ultimate goal of finding ways of re-structuring their experience which leads to them finding their own solutions to those problems and difficulties.

If the research interview were viewed in a similar fashion, the main goals of the interview would be to help the interview subject to feel comfortable enough to share information with the interviewer about how they are experiencing the world particularly in relation to the issue being researched. The interview subject is then facilitated through a process in which they can accurately uncover the deeper structure of how their particular view of the world in relation to the issue being studied has arisen, with the ultimate goal of them being able to share a thick description of their view of the world with the interviewer.

Fuzzy Predictions

In order to make sense of the conclusions of the study and to make the findings and conclusions potentially useful to education managers, a series of fuzzy predictions or fuzzy generalisations has been formulated. Fuzzy predictions as described by Bassey (2001) provide '*... a powerful and user-friendly summary which can serve as a guide to professional action*'. The fuzzy prediction is expressed in the form : '*particular events may lead to particular consequences*'.

The notion of fuzzy predictions has a counterpart in the world of NLP, which is the idea of the 'as if' frame. The reader is asked to consider the statements 'as if' they were true, and encouraged to then check this out. The checking out could be via a major research project or could be testing out the predictions in their own individual circumstances. The following represents a re-working of some of the conclusions and recommendations of the study into fuzzy predictions.

- The apparent conflicting nature of perceptions of stakeholders of fitness for purpose in the education of Mental health nurses may be illusory. There is a set of skills which may facilitate the management of this issue.

- The current formal methods for the commissioning of the education may not be effective in establishing the 'real' needs of stakeholders. This phenomenon may be a function of the formal nature of the commissioning and contracting process.
- Attempts to manage stakeholder perceptions which do not uncover the underlying and usually unstated perceptions may result in the commissioning of education which does not meet the fitness for purpose paradigm. This again may be due to the formal nature of the commissioning and contracting process.
- There are sets of 'Big Picture' skills which are commonly articulated during meetings of stakeholders and which include advanced counselling and therapeutic skills. These skills, although articulated and much requested, may not represent the 'real' perceived needs.
- There are sets of 'Small Picture' or very basic communications skills which may be common to stakeholders regardless of their main areas of concern regarding the education of mental health nurses. These Small Picture needs may be closer to the perceived 'real' needs.
- The individual stakeholders may believe that the need for these basic communication skills is a perception which is not shared by other stakeholders, and if the need were to be publicly articulated, might reflect badly upon them.
- It may be possible to uncover the 'real' perceptions of the stakeholders by the use of rapport skills and meta model questioning techniques.
- The bidding process which is commonly utilised in the commissioning of a new course, may be counter-productive in collaborative terms, in that it encourages individual institutions to compete rather than collaborate.
- The establishment of the role of mental health education liaison officer with those skills necessary to establish the needs of the stakeholders may facilitate the management of the process.
- The development of a training programme for education managers and commissioners in the use of rapport skills and meta model

questioning techniques may facilitate precision in establishing the real needs, and may further facilitate the ability of the stakeholders to articulate their needs.

- It may be possible that other areas of education for health professionals are experiencing similar difficulties in the management of the apparently conflicting perceptions of stakeholders. This may further apply in the much wider educational context. Some research is needed here.
- The skills of rapport and the questioning techniques of the meta model may be useful tools for research interviewing. They could provide a useful framework for interviews which balances the digging for information with the non-contamination of the material.

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Notes on Appendices

Please note the following with regard to the appendices;

Appendices 1 and 2

Appendix 1 has not been reproduced in full, as sufficient was produced to show the use of the interview methodology, inclusion of further material may have led to identification of the subject. Appendix 2 has been reproduced in full, other than the removal of all material which could potentially result in the identification of the individual interview subject. The format of Appendix 2 is in text only with line breaks, which is the format utilised to input the data into the software analysis package.

I am, however, aware, that given sufficient knowledge, a will to do so and a certain degree of diligence, there is a small chance that subjects could potentially be identified. I have taken every possible precaution against this happening, and would ask that the reader respects this.

Appendix 3

The index system evolved and changed continually throughout the lifespan of the project, particularly in the latter stages of analysis of the data. Particularly extensive use was made of text searching in the coding stage, and in the interests of brevity only the final 30 text searches are shown.

Appendix 4

All of the ethical codes listed were studied and the principles adhered to throughout the lifespan of this project.

List of Appendices

1. Example transcript from Education Stakeholder Group
2. Example Transcript from Service Provider Stakeholder Group
3. Final version of NUD*IST index system utilised for coding of data from interviews.
4. List of ethical codes adhered to in the production of this study.

Appendix 1 Transcript from Education Stakeholder

F thanks J for seeing me. You know what I'm looking at because I've sort of talked briefly to you about it before

J yes I do yeh

F but just to recap very briefly; I'm looking at the stakeholders perceptions of mental health nurse education, what those different perceptions are and ultimately how that might be managed if it can be managed so the context is really any context you wanna talk from is good basically,

J mm hmm

F so its really just your notions, your ideas on what you think mental health nurse education ought to be about. So over to you really what do you think?

J well it's a fairly broad brief, well I suppose I have a fairly pragmatic view really. It seems to me to be, well my preference would be for mental health nurse training to be firmly located in the interpersonal domain. It seems to me that interpersonal skills provide the the corridors (??) or vehicle through which any care is possible. I would have to have a rider to that because we have this language problem - almost anything we say is a bit tired, a bit clichéd. So when I think about interpersonal skills, I'm not uniquely referring to specialised counselling skills and so on - but I am thinking more, rather about interpersonal competence required in a range of typical and specific interaction contexts that are characteristic of the normal practice of the mental health nurse.

F - for example?

J - well if we take our vantage point from the perception of what research is available, which is a bit piece-meal, but if we look at for instance the research about the presence of user-care perspectives - that's the perception of preferences and concerns expressed by patients and their carers, then a number of interaction contexts seem to be more or less, as a rule of thumb, you could roughly define them. Whether or not we could pare these down to process is another matter but my inclination is that we probably could. So contexts might be defined by invariably the factors that impact the variable influence on any interaction between a client or a carer. So - commonplace interaction contexts. And that term is a term of convenience, would be things like events such as admission to hospital, it's a key term which represents an

opportunity for the patient and the nurse and the carer to clarify a whole range of issues relevant to care. Other interaction contexts that tend to be typical in the adult in-patient service spring from special conditions of care for instance the process of special observations for instance is unique to mental health with its concerns for risk assessment and support of especially vulnerable clients. So that would be sort of summarising the sort of thing I mean but obviously its very loose

F - so take one of them then - say the admission process. What precisely would you expect the nurse to know to do? What should we be teaching them?

J - well I think at this point the conversation becomes a little bit more controversial.

With a small scene, not only in the sense that I think we have to reinvent the wheel

somewhat. I think the nurses' capacity to interact is hugely influenced by their

understanding of the impact of mental illness on the patient and the patients family so

according to that perspective, the term mental illness has become a word which we

prefer not to use. Coming from that perspective, the assessment interview on admission to hospital, really is a high watermark and should be conducted by a highly

skilled practitioner into which the student, can provide a context into which the

student is introduced. So such events could be, I would prefer such events to be the

primary vehicle for clinical supervision or mentorship of student nurses so what the

student witnesses is an experience is participation in a process very similar to an

advanced practitioner. Clearly this has a feedback into curricular matters, directly in

terms of specific inclination, aspects of the information, indicative content for lecture

material for instance. It also has a feedback seemingly that would be about uniform

signs symptoms or disorders or whatever language we prefer to use. But it has a further impact in that there needs to be space within the curriculum of practical space

and time for managed events which are not about information but which focus on how

to conduct and facilitate such processes and my inclination is that the development of

interactive competence in context throughout that requires a lot of rehearsal. So the

model that would come out of the other end of this discussion we [planned would be

(a) that there is a requirement for very specific and very discreet indicative content

which is available in the public domain for the student to appeal to in terms of an

adequate reference which is about the research on the impact of mental disorder on an

individual and their family whether it be depression or schizophrenia anxiety

whatever. The secondary requirement (b) we would have to sign up to a commitment

to create space and time within the university schedules of teaching for what we used
to call experiential learning events which were role play workshops designed to echo
or mimic - no, echo the range of feelings and concerns that a new , emerging
professional would experience in those situations so the student would increase
a
sense of heightened personal salience in potentially unpredictable situations.
If we
got to model something like that, the prospect that this model would map to the
students direct experience in practice would be increased. So when the student
came
into the workshop scenario or situation, we might have prospect that the student
would go into that situation, actual scenarios of observed and participatory
experience
of these real events and would have the opportunity for these events to be
explored in
somewhat more detail by the advanced practitioner who is providing the support
at
the university i.e. you or I. so that's the sort of model, but there are a wider
range of
interaction contexts that would need to be looked at.

F - the notion is to explore real time events as though they happened or I'd
like
them to happen

J - and add that to present knowledge base... for example if we just take the
admission assessment as convenient example, we could map that process to what we
understand i.e. what research tells us, keep a range of expectations concerns
and
anxieties people bring to that context both the client and where the client is
fortunate
the clients relatives family friends partners and carers. I think it also go
without
saying that this mapping process, the relationship between the reference based
expressed in terms of present research and perhaps a discourse on what is
presently
controversial in mental health, that's critical. But what's critical is that
what comes
out the other end for the student is a heightened sense of personal competence
in a
whole range of very specific interaction contexts

F - and the knowledge base for that?

J - well the knowledge base is variable in the sense that the research is
critical but
the reference base or the domains of the research which we would look at is a
fairly
wide portfolio so clearly we've mentioned research which presents client user
testament about their experiences. Clearly there's also research that feeds
directly
into those processes which we might miss coz it might seem marginal e.g.
research
from the can in relation to the impact of stress or what's often referred to as
burn out
in nursing therapeutic attitudes and therapeutic competence in the sense that to
be
aware of the likely consequences of feeling out of control i.e. burn out might
be to

increase the prospects of an individuals developing some sort of emotional buffer and insight into the words we might understand interpersonal work to impact on the work as a therapist would be critical here.

F - if you've done extensive research and work into the teaching of professional skills, I just wonder if you wanna say a bit about that? What you found in your research?

J - where to start? In terms of how it connects directly to what we're discussing now ... some of the feedback from students taken by data extracted by teaching process, facilitation process and so forth. What that tells me is there's a considerable distance between the recipe and the pie and that in provision of experiential sessions and I use that word as shorthand, where students are offered the opportunity of nominating specific interaction contexts they would like to explore in a way which requires increased personal salience i.e. list taking role playing from aspects of events from memory sharing the details of those events, both the cognitive appraisal and emotional responses in a variety of ways that opportunity to revisit those events in a highly vivid way which students have most highly evaluated and also the sense that the opportunity for shared resolution of individual concerns anxieties and also celebration of good outcomes. So it's more than just the talk chalk aspect. Clearly there was, I'm talking about feedback from processes that were evaluated over 3-4 years so I'm talking in general terms about what was consistently evaluated positively. And what's often been said is that the opportunity to explore what might be for one member of the group a novel event by a context which they've not yet encountered, provides them with (or it's worked out in practice) that when they meet that event, they've got a cognitive model and I use that word very loosely, an emotional model and also a sense of self in interaction from which to problem solve and second guess how best to interact. E.g. if we had the leisure to take a historical look at advice from the great and good, students often pick the notion that in interaction with an individual person who has autistic problems involving well integrated hallucinations and delusions they often pick up the advice from their reading of standard texts that the one thing they should not do is reinforce the clients present sense of self i.e. their delusions. Now the first difficulty the student encounters is that this is a strategy which directly isolates them from the emotional reality of the client. So we find this in sense sensible sounding advice deeply unhelpful. In role playing these scenarios that involve this type of interaction, students have offered and been facilitated also, these sessions have typically been facilitated by more than one member of staff so there's a high resource factor.

A

variety of strategies born from experience on how we can perhaps mix a level of emotional contact with the client, the client who is presently feeling isolated, estranged, vulnerable, fearful and so on. Some of these strategies seem to run contrary to the advice from standard texts, perhaps they might not, but in relation to the students interpretation. They have yielded fruitful dividends, and may involve trying to share a sense of emotional contact with the client rather than an intellectual level of contact. And this is one of the key difficulties that the new practitioner experiences.

F - coz you can go further into the opportunity to experience what it might be like to have that kind of hallucinogenic experience

J - well we also do do that> that's a sort of high water mark and a good ice-breaker for that approach is the simulation of interaction with someone who is hearing voices and we set that up using a whisper mic and it's a startling revelation to most of the group, a good ice breaker and can be done, in fact needs to be done on several levels its often a session we come back to with more scripted detail as people develop confidence in being salient with the group.

F - so the model is one of you have them encounter several different types of scenarios and for those different types of scenarios, you will need wide wide varied and specific interpersonal skills.

J - I think the notion here is that our concept of skill sits on grounded awareness and understanding without which there can be no practice as an option. So a clarification of that statement, over the years, we've had student s who have experienced counselling and what they've found very rapidly is, whilst it is clearly an advantage, marking their counselling skills or their awareness of their skills their sense of self as a therapist as it were, is enormously complex particularly in the adult in patient acute setting and its not until they develop a sense of self which is grounded in the commonality of experience and the sorts of situations which are commonplace, often dramatic in interpersonal terms that variable to moderately understanding basic counselling skills might be used to good effect. So the model here is, yes we need to focus on interaction skills but they need to conform and be supported by a shared and consensual understanding of how we might best proceed in a variety of situations

F - and consensus would be between?

J - I think the thing to emerge here is a sense that mental health practice is not an individualistic practice. It's a practice that sits on shared concern and consensual

resolutions to shared concerns so for instance the simple idea here is that there are 2 things that student nurses learn very quickly - and this was expressed to me very eloquently by a colleague (1) is that there are never enough staff and (2) those staff who are available never have enough time. A consequence of this is that mental health staff in practice learn very early on that although there is acknowledgement of the primary nurse model and the key worker model and the individualistic focus of the nurse patient relationship, it is quite clear that students learn, or as they learn, they learn to appreciate that they need to interact as a member of the team. And that the most effective progress in care particularly with clients who have complex and difficult problems is via a process of consensus on the way forward. And I think this is quite a liberating realisation for most students

F - this fits in very much with discussions I've had previously with for instance people at the northern centre. Are you aware of the work they've been doing on the in-patient collaborating

J - I know about it yeh, but I wouldn't say that I was aware

F - I'll just run it past you then ... it may be connected to what you're saying. I'm connecting it anyway. The notion there is that you have a unit in which everybody is a member of the team including the client, the patient, the relatives, the nurse, the student, the psychiatrist, everyone who's a member of the team who collaborate with each other to decide on standards and then agree a set of set of standards, and evaluate them and get pin points. The notion was that what was most important in that was the fact that people had the skills of being able to negotiate and come to a shared understanding of what care is about. I just wonder how vital you think those skills are in terms of being able to teach those skills to the students.

J - well I think they are critical skills. But I think also there's another layer of influence here, but I'll give you an example .. I remember vividly talking this through with a client who had a very long history of repeated admission. And his admissions were always attended with - the context was usually dramatic, involving the police and a 136 and detention. And I asked this person what was about what was he most fearful and concerned on these occasions and I suppose its interesting to note incidentally that this chap was a great big man physically. And he said the most terrifying aspect of being in hospital, which, I must say he evaluated generally very

well as he progressed through each episode of care. The most fearful aspect of being in hospital was being invited by the staff to, as he said, socialise, and he said he found this very difficult because typically his mental problem tended to isolate him socially and so I suppose it meant, short-hand really, we are talking about the erosion of interactive or social skill in the individual because of mental illness. Now the concern that this flags up is I think probably a material, or of materially significance concerning many incidents of care. It's one thing to have a very clear professional agenda and to recognise as we rightly would that this chap would profit from interaction with other clients and staff and all and sundry - and one could see this in the nursing record. You can imagine the cunning plan in the nursing record. And certainly we would all sign up to it but clearly it's the key here that negotiation must be moderated by an understanding of quite what this means. Now this looks like something quite simple, but for this chap, something that looks simple is a huge challenge. So, I would sign up to the idea that negotiation skills are pre-eminent but it must be negotiation based on awareness and empathic understanding of the client and the carers point of view. And the question that raises for me is how units of practice in patient care go about facilitating that empathic understanding of the client and carers perspective so I suppose that brings us back to, certainly it embraces the spirit of partnership and the CPA approach generally but it comes back to the detail of how key events are managed. So - who is it that does that at reception and admission and who is it and what skill have they got to encourage that client to interact? Which raises a new layer of questions which might take us away from the focus of your enquiry but impacts directly on the quality of the placement as a learning environment.

The other thing that comes out of the research, not just my research but across the board, one of the key features which is on the tail is the practical observation that it is still the case that the majority of care and if we style care here as interaction, the majority of care experienced by carers and clients is with perhaps undervalued under-prepared auxiliary staff, health care assistants and the like. So I think in terms of raising the game for mental health nurse training I think we also need to consider what's in the background in terms of what skill base is available on these wards in placements amongst ancillary staff

F - so we're still at the scenario where the least qualified, the least experienced, the

least skilled perhaps, are giving the most care if you define that by interaction

J - yes

F - there's 2 questions in that then (1) how would we change it and (2) how has it occurred?

J - well I think it's occurrence is historical. Certainly when I was a student nurse which is a long time ago - 30 years ago, the student nurses provided the cheap labour force for the day to day activity in large psychiatric hospitals. Now as nurse education has evolved, the role of the student congregated in bygone times is now provided by health care assistants. Which raises a number of complicated questions in the sense that the idea that we've changed practice simply by changing formal education seems to be a non starter. If we look at the, and certainly my main interest is within the adult in-patient sector. If we look at the through-put in terms of bed occupancy - the clamour for care, and the stresses that those units are universally under. And then we look at the staffing establishment and we look at the skill mix available on a shift by shift basis, then we might have a number of concerns. Particularly, if we are in this situation, on a shift by shift basis, and this is straight-forward numbers: when we asked the question how much skill is available for the patient in terms of patient interaction, and we note that in some instances there are perhaps one nurse or even 2 nurses on shift and we ask ourselves what it is those nurses are doing and fairly often and this is an empirically observed fact - it isn't my impression. Often what those nurses are doing is managing the shift. And their interaction with clients tends to be reserved for difficult to manage situation i.e. emergency occurrences, or its down to random chance. And most of the interaction is occurring with people without the benefit of such excellent preparation as these nurses may have had. So in looking at how we might address those concerns, and clearly these are all issues which need to be discussed and resolved at Trust level. What the students tell us, certainly what they've told me over the years in recent years is that often their experience has been characterised by high points, shall we say peak experiences in terms of professional learning that they carry on to have a definite influence on their future practice. But those high points of being involved in excellent practice in terms of interaction with

clients tend to be embedded in a pattern of events which is mundane and within which they are prone to misguidance by the best intentions of unqualified staff

F - what would be an example of one of the high points?

J - well an example of a high point might be how to effectively resolve an emotional crisis for a client, so they witness interaction between an experienced competent clinician on how to approach this situation and they have then an overall model for it. In the best case scenario this advanced practitioner might also be their mentor who might also then note the value of talking through the process of this real event with their student. The student notes this then as a peak learning experience. But this tends then to be situated ... and it's a bit of a lottery for the student in terms of who they get as their mentor, how busy that person is with other matters, managing the shift etc. but those peak experiences tend to be situated in the day round lottery of observing and interacting with patients predominantly with health care assistants, some of whom are excellent and most are well intentioned but often misguided

F - so fitting all of that what you've said into the political centre, and you've got the national service framework, with people telling us what ought to be in mental health training all over the place, how would that sit within the political scenario?

J - its hard to speak in detail about something as aspirational as the National Service Framework for mental health. I think if I was to flag up one key element in the NSF which touches on our discussions, I think the key element is the emphasis on partnership, the emphasis on the need to, and I do think this is aspirational, and I think it's a concept that most advanced practitioners would sign up to, sign up to daily in their practice as it were. But the idea that excellency in the deliverance of mental health care sits on effective understanding and consensual agreement on best cases of practice for individuals... So I suppose what I'm saying really is that the key element in the NSF for me is the emphasis on partnership. Quite how that would be facilitated as the strategy is developed, is another matter which would be interesting to note.

F - so if we were throwing it all out tomorrow and starting again, you know, we've done that sort of thing

J - no I don't think we have. I think what we've done since I started as a student nurse, we've not really had any radical reformation of mental health nurse training

and certainly if we were starting again I would start from that premise - that what we want is a radical reformation of mental health nurse training. What we've done and it sounds critical, its not meant to be, it sounds critical in the negative sense, what we've done is persistently changed the plates around on the dresser and given a blank sheet of carte blanche per se. I would start from a completely new, entirely different premise

F - completely new?

J - such discussion hardly warrants air space. And I suppose there's been a trade off historically in the sense that the move out of hospitals and into Higher Education sphere is broadly liberating for both teachers and students. Its increased enormously the sense of value with an adequate reference base by which I mean research and discourse, within which to situate discussions profits and practice madness - we couldn't even begin to estimate the value of this. One of the problems in this process is that its taking mental health nurse training hand in glove with nurse training and I think the identity of mental heath nursing has been weakened through this process. And this is not new for me in the sense that I am quite old fashioned in some respects and I do think that there's an enormous value to be gained from, as a mental health practitioner, to be gained from having a firm grounding in the roundness of care and an understanding of physical care and I'm general trained as well so I suppose that's a historical bias on my part. But given carte blanche, I would take mental health nurse training out of Project 2000 entirely and I would like to see investment in the development of restructuring of professional preparation for mental health practice. I think that we need to embrace shared practices on the margins of professional roles with colleagues in social work and other areas but I would, like I mentioned to see that as the way forward so that a student aspiring to mental health practice s a nurse would have a clear dedicated programme rather than a shared programme and I think that would be the first point from which I would start

F - the notion that they would then still be a nurse, would they still be right?

J - well this is one of those issues that goes around and comes around. How do we define a nurse? How do we differentiate the nurse from the social worker, this is the thing isn't it? This isn't especially difficult for me but this might again be rooted in old fashioned historical artefact of my experience in the sense that a huge waft of

concerns associated with a detailed understanding of the impact of mental health problems, as we now choose to call them, on the individual, and in the roundness of that understanding, one does need insight into physical processes and a whole range of specific clinical observation and monitoring and administration skills - and I'm not simply referring to giving out medicines but a rounded understanding of the interaction between mind and body. The extent to which this is required in social work, it's not my place to say.

F - but you would say from?

J - yes I would.

F - right I'm just about at the end. Is there anything about the management of the whole thing that you can comment on? Cause you know where I'm starting from and you've given me a really clear notion of your view as a stakeholder, what would be required of a mental health nurse? And how might that be managed?

J - I suppose my contribution is obviously inevitably biased and it's been somewhat partial. One of my rolling concerns is that like healthcare per se, mental health education has tended to be a bit of a political football. So if we look at trends in recent years, the influence on these trends are basically a historical pattern. The closure of the mental health hospitals was politically supported implementation of a model consensus but the investment in programmes for interventions such as PI and other growth initiatives such as the early intervention programmes for young people with schizophrenia - these programmes are excellent. But one of the concerns that I have is that other aspects or other skilled domains or other practice domains have tended then to be somewhat marginalised and I would point in 2 directions here - one would be toward adult education acute services which has suffered greatly with the seepage of skilled staff into attractive rewarding challenging roles in the community. The other area that's suffered is care of the elderly mentally ill which as increasingly been seen as less attractive to the young enthusiastic staff and I would like to see a more rational forum for a wider discussion of mental health nursing and mental health nurse training rather than this "let's catch the rabbit" approach that we've had in recent times. If we for instance went tomorrow and asked service providers what courses they wanted, probably the answer we would get would be that they want more courses on brief interventions, cognitive behaviour therapy for instance. We would

want more envelope courses on psycho-social intervention. That's the sort of answer we would get and my impression is - whilst those initiatives are hugely important, taking that approach to nurse education CPD - we mustn't forget CPD which is hugely important, is probably not the most rational way upon which to plan for the future.

F - so would that be a minority concern? Yes we're gonna need some people with these skills but it isn't the biggest concern.

J - I think when we had this discussion at practice level, really in some sense we responded to pressing anxieties. One such anxiety was how to deliver a rapidly changing service which on all fronts has a growing demand so that in a sense there are concerns about how best to develop an education infrastructure to support a skill base for mental health and there are concerns about how best to develop and deliver a varied service for mental health. Now these two issues are not the same although they are related. Clearly there must be some interaction in terms of the discourse but if nurse education or higher education can only proceed on the idea that we must deliver to the client what the client wants today, then the concept that we ever develop new and innovative, if you look at courses programmes that have long lasting work is clearly flawed reasoning.

F - compared to higher education, this (???) is an enormous ocean liner that takes a hell of long time to turn round

J - yeh, so is the NHS.

F - okay, anything that I've missed? Anything you wish I'd asked you about that you'd like to say?

J - no, I suppose its hard to focus on how I might be helpful

F - last question then - if there was one thing you wanted me to remember about what you've said, what would it be?

J - well I've mentioned concerns which are in the reference base for anyone to consult in relation to the fact that provision and resource management in adult in patient acute services, I think with respect to training up to pre-reg, or education up to pre-reg, I think that my most important notion really is - id like us to reinvent the wheel and put back into pre-reg space for (and I appreciate the resource implications of this) but space for facilitated inter-personal experiential workshops facilitated by advanced education practitioners like you and I. that would be the key thing for that. With respect to CPD I would think that higher education needs a more open brief to

develop innovative programmes rather than simply being responsive to requirements that happen to be topical today or tomorrow.

F - thank you very much.

Appendix 2 Interview Transcript form Service Provider

F

well L thank you very much for agreeing to see me I have explained what it is that I'm looking at, I haven't got any really structured questions I want to ask, I have my own way of doing it. It is about talking about the perceptions of all the different stakeholders within mental health nursing, and the education of those nurses. So it is rarely anything you want to tell me about your perception of the education of mental health nurses.

L

that's the kind of broad place to start, I sort of hoped that you might narrow me in a bit. I would be interested to for instance in what M had to say, given that I was involved in interviewing him not that long ago for a similar kind of research. I don't know whether you know, but I did a project for the west Yorkshire consortium.

F

yes I did L, I've read it, digested, and included in my literature review.

L

OK that is a good place to start then. M is for me, not a guru, but, and who in his own way knows what there is to know, and I think it has done very well for himself in terms of coming to Yorkshire, setting up the Northern Centre, which keeps growing now. And I think in terms of the impact on mental health nursing and the education and training, that at one point, about 18 months ago, when the whole thing was almost Mafia-ised, the direction was really elitist. There wasn't really any consultation, there was really any meaningful examination of what people's perceptions were at a local level. Part of the work that I do it and, you know, if you read the document, it is sanitised to a certain extent because, I think D and I would have liked to have put a lot more in that it's difficult sometimes to tell unpalatable truths. Especially when you are working for the Consortium at the time. So M is a good place to start, and I would be interested, perhaps you could interject with some other things that he had to say. For me, I think, I don't know whether, I think there was a couple of years ago the beginnings of a shift towards a better understanding of the whole area in terms of there were and number of specific pieces of work that were undertaken that have gone on for instance pulling together, pulling together 2 that sadly disappeared, a lot of work about competencies. A lot of work about the potential for individual groups in mental health working and learning together. And that was from a Zero base up to a very high level. And that for me was, as a person very interested in education, and interested in nursing, was hopeful, you know things seemed to be moving on. I'm saying seemed to be moving on, because I think my perspective of that now is that your hopes don't necessarily transpire into the reality.

F

what not immediately?

L

yesterday and saying more time is required, you know, big beast big job. Large organisations take a long time to slow down, stop, turnaround, but it seemed to me that there was a huge amount of enthusiasm to change things on a very very pragmatic

level. On the face of it, at least, it wouldn't be a difficult exercise, but I think what is probably, I think my own particular take on this is, the strategic agenda on mental health has just gone absolutely crazy really. So the work I have been involved with in the modernisation agenda shows that I think there are about 79 or eighty outstanding items of mental health policy at the moment. So education and training becomes one sort of football, on the pitch, although one of the things I am trying to do locally is to tie everything together into a very broad workforce arena, because the key things, you know if you are going to change anything it's not done through machinery, it's not done through buying more computers, or buying new buildings and new cars and more paperwork, it's done by investing in staff. I think that one of the big messages that is coming back to the government at the moment is that there is a problem with the workforce, the workforce is not advancing in its capacity or capability at anything like the rate that is necessary to deliver the changes that are happening in mental health that they have outlined. I would say that the changes in mental health are more significant than any other area of healthcare. You might say that you are slightly biased because you are in mental health. I think that other areas would struggle with the breadth and depth of the agenda that we have to tackle. So for me, the really big issues, are about getting that across, and until we tackle these issues, until we really seriously point on a very high policy and strategic level and also on a very pragmatic level to deal with and unravel these sorts of problems, and really seriously address them because the issues of supporting and developing staff have always been, in retrospect. The government comes in, wants to change things, and says right will change this, we'll change that, we'll change this organisation, and the latest think that comes out from the universities or comes out from America and we think this is a good idea. Get on with it, do it. And only when you start to do it, do you then start think about all we can't do this because we don't have anybody who knows how to do it. The workforce haven't been developed. So there are all those challenges. There are two my mind challenges to nursing itself.

F
what kind of challenges?

L
professions are under attack, from the government point of view. The medical profession are under serious attack, they have had a lot of bad press recently as well, but nursing stands next to medicine as well so that when the shit hits the fan, some of it is going to fly off and hit nursing. But I also think that the government uses some of this as a vehicle for forcing through change. Remained nurses are flexible and adaptable in other ways that other professions are not. Whatever you want to say about us is a broader church, we are flexible, we are profession that wants to take on new things. If you lined up all your health professionals, there is no way that they could stand up to the rate of pace of change that has gone on in nursing for instance, over the last ten years. Just to concentrate on mental health nursing, but there are other areas as well everything is coming out as policy is, the Department of Health has just recently invested money in quality of leadership programmes, which on the face of it is a good idea. But the other side of that it is the implicit criticism that there is no leadership in nursing. And certain types of nursing is worse than others. And mental health is one of those types. I would be interested to know what M thinks of this because I know that M is connected with the leadership programmes as I am myself.

F

when I spoke to him, he sounded really positive about it. He seemed to be coming from a stance that mental health first, because mental health is interested, not because mental health was being targeted.

L

well maybe I am just being paranoid. Mind you I wouldn't expect him to come from any other position being in the position he is.

F

I suppose it's best to say that at this point, that M and I go a long way back, we geared to the clinical teachers course together way back so we have known each other for a long time. It was a relaxed what we talked, but of course he is part politician.

L

I am glad that he is positive about it. When I say that it is under attack, some of it is explicit, and some of it is like, there are subtle things that are going on that undermine the status of the profession. And what I am coming round to talk about it is workforce developments and the education of the workforce, local training of the workforce and the emphasis that is put on that. I was hopeful 18 months to two years ago, that things are going to change, that things would be, you know, quite clearly you can look now, there are documents there, lots of pieces of work around. You can quite clearly say what is a recipe for a good mental health nurse? Or a good mental health practitioner? Of but kind of profession. And you can also pick up from that some good ideas about the future of mental health worker. What possibilities there are to join up to overlap etc. for example with mental health nurses and social workers, but that seems to have been some subsumed by this massive policy agenda that is politically driven. It has put his right back where we started from which is you will deliver service change, but you will do it without the necessary resources. The implications of that are that the work of the profession is weakened by that. Because the strength of the profession is in its knowledge and through its knowledge its expert practice. It is fair to say that those things have been on the agenda a long while. You have got a large number of mental health nurses working both in community and hospital settings, who I would regard as de-skilled, because time has moved on and expectations have moved on but development hasn't. I wonder if you could say the same for other professions, I doubt it.

F

what do you mean by the other professions do you mean solicitors, dentists that kind of thing?

L

yes I mean things like professions like teaching the law, that kind of thing. Teachers by the nature of what they do are well connected to self-development they seem on the whole to be, generally speaking better trained, better developed, than nurses. Nursing hasn't freely sorted itself out in the longer term. I know that you do have nurses who have PhD's right through to nurses who have done very little development. I could go and show you people like that who have been hiding away on nights, they are not difficult to find. And that worries me, people become

disenchanted, disenfranchised, it then becomes really difficult to reengage those people. If you have a shiny new university or a brand new Confederation comes along and says they can do things for this person, they don't want to know. If you can get them into the class under duress, that is another issue when you get people who are in the class who don't really want to be there. I'm talking about people you can't even get in there. That is a real issue for the consortia to sort out. They need to sort this issue out. I can't remember if we touched upon this issue in the square pegs report, it is something about, the university is doing a good job of what they are actually charged to do. But universities are frightening places for people who haven't got any qualifications to speak of. There are likely to say Hey I'm going to walk down to the university and find out what is going on. They are very difficult places for them, there is a language barrier. I feel very strongly that the consortia needs to support to those kinds of things, it needs to work together very closely with the local provider institutions. And the local commissioners that are emerging now. They need to look at the total needs of the workforce. Because we need to find a way of assertively out reaching these individuals. That's the analogy that we need to apply. We have got mental health patients that we need to reach in that way and I am damn sure we have mental health staff that we need to reach in the same way. There are some professions for instance doctors psychologists etc. that are very much more focused on their own development. That could be a good thing or a bad thing and I think perhaps it's gone too far, for instance psychologists who are on the fringes of mental health, I would be person who would be arguing to bring them back into the mainstream arena. So the big issue around at that particular question is, you can't expect the universities to do that, the universities do what they do, and they are good at doing what they do. What we need for services that augment access universities. One of the things that interests me, we had a bit of a flurry this week about to the NHS university, which is an interesting concept. I'm not sure how is going to work but in theory it is a damn good idea. It is a bit like whoever invented the washing machine, or why did we have that before? That could be a way forward, it could be a way of dealing with it. It could be dealt with on a more open approach. But it will only work if it works with employers, and employers are helped to identify needs within groups, and they are helped to identify access channels. Because it is difficult, I know from my own personal experience, I have a master's degree, but I only half that because I am big enough and bold enough to have walked into a university and know that I had the qualifications to apply for it. And I was big enough and bold enough to go and argue with the course leader that I had the capability to do the course. It takes a deal of determination and the degree of courage to be able to do that. I did that with the University of Sheffield, they were very good actually, and I can normally speak volumes of praise for them. I did have contact with other universities who wear, shall I say, very snobby. They were not interested, and if that is my experience as a person who has been around the NHS a long time and has done different jobs, and has worked with a lot of people in senior jobs, then what is it like for a staff nurse on nights.

F

it's just not going to happen is it?

L

that is sad, because there is so much unexplored potential in individuals. There is a problem of resources, these things cost money. If you want the quality resources you

are going to have to put your hand in your pocket. If you can afford it, if you are capable of paying it. This is good if it is targeted where it is needed. I don't know if you saw it, but after Gordon Brown's speech they did a things were they went with a camera to a few nurses in blue uniforms, and that bit that I saw was there were a couple of nurses who were saying that it was good what Gordon Brown had said but will only be good if the money goes on pay. Which, OK we would all like to be paid a little bit more, no one is going to say I don't want that extra thousand pounds. If they had interviewed me I would have said make sure the money goes to where it is going to make a difference and that is in training staff. The organisation really needs to invest in its staff if it is going to grow and develop. Or whether we are going to see and massive increase in that I don't know we have seen the consortia changed to a Confederation. There are possibilities are about joining budgets up and you know all that sort of stuff, but at the end of the day if you can't how much they spend in industry compared to how much they spend the NHS per capita, it is abysmal. And that is because, Frank, they write people off. For everyone person who does a master's course for a PhD there are ten people who basically do nothing and slowly decay.

F

I have two questions then two ideas I would like to explore, let's take your mythical, apocryphal, staff nurse at night duty who is going to be one of those who doesn't and hasn't taken up any training, what can we do for her, and what could we have done to have stopped her becoming like that at the first place?

L

I have already argued that I would push for an assertive outreach type of education programme. I can't be necessarily too clear about how we would do that, but, there are many ways of communicating with people now, but a lot of those ways are quite passive. Web sites for instance, are OK, as long as people look up that. I view them as a passive device. What we need active devices, and the most active devices I can think of are people. So that I think we need to do is to employ people to go out and to meet people and to make those links. This would join up what's happening in the universities with what's happening with people's needs. It could be done in a number of ways, it could be someone who is just passing and goes into the ward to say these are the kinds of things that are going on in the University etc. wasn't there something that one time about the tutors who are working in universities going out to the wards and making those kinds of links.

F

yes that kind of thing does happen and I have some personal experience of that

L

was a difficult experience then?

F

yes and no, it was certainly a very enlightening experience. For the first two or three weeks that I went, I was accepted with open arms, and then it got too, well I'm sorry but we have a doctor's round going on at the moment. I started to get under their feet.

L

but that's where if, for instance you take assertive outreach, you just go with them anyway you say or I'll come on the doctors round with you, and we can see what we can learn about for instance nursing leadership. That would be my argument, it wouldn't be cheap! I don't know what the expenditure currently is on passive things if you took that cost away, take all the money away that is invested in that and move it to an assertive outreach type of system, it might help. There certainly isn't enough money in the system, I mean I don't know how much there is in the education system, but for training needs there isn't enough money in the kitty. I know that people use education and training almost interchangeably, I think about training as a shorter term, focused, sort of activity that could be skills focused. There could be an element of that at its best delivered locally, in short timescale within a project. A lot of the problems attached to short training programmes is that they can tend to become wishy washy, instead of being assertive and going out and delivering the message. Education, by its nature, has to be a bit reactive. I would argue for education and training being two completely separate paradigms. Training can be a vehicle for getting people into education. If you have got good effective training it will do that, it will get people interested in education. There might be some good examples of that but I am not aware of any at least not in West Yorkshire. You asked about how we can prevent those sorts of things happening, well how do you prevent any poor state of affairs from coming about? It is by investment in that individual, that is through providing resources and providing channels into education. It is also about effective management of people. People get into difficulty in for instance through bad practice, poor management, nobody taking an interest in them. That might be because there is no system for that to operate in. Organisations operate all sorts of frameworks, but do they actually operate frameworks that help individuals to develop. Do they really look at needs and follow that up rigorously? It comes back again to what I was saying about, one of the things that the nursing profession is under attack for at the moment is about leadership and about clinical leadership. If you don't have a good localised leadership, then that's what happens. People fall between the cracks, people hide the corridors, people are swept under the carpet. They are hidden from view and become comfortable with that. Then they become burnt out I suppose, burnt out isn't really the right term, that implies that they were actually burning at one point. They have just gently fizzled out I think. I have been in the nursing now for about 18 years now and I have seen a lot of people get into difficulties like that. I have replaced people who have been those sorts of difficulties. I suppose when I was younger I would have thought, more fool them, why are they such dinosaurs? Without any understanding of how people got into the situation, I was very dismissive of such people, I tend to be much less dismissive of people now and think well how did they get into the situation, now I believe that there is potential in well almost everybody. I want to say everybody because that's not true but almost everybody. So how do you prevent people from getting into that kind of situation? You provide decent shift systems, you provide reviews where you look at people's education and training needs, in the context of where they are working and in the context of the whole health service. I don't think we have that, I don't think we have the yardsticks. For instance say I am a ward manager, things are changing so fast, the yardsticks are not that easily identifiable. There are things like, I was very impressed by the capable practitioner, which I thought was a nice concise piece of work. If I was a ward manager I would be using that, and other documents of that ilk, to assess my workforce, I would benchmark my workforce against that. I would be saying, this is what they are saying that we need, I think that the struggle that I was trying to come to maybe was that, we've got things

like that we've got to documents like the capable practitioner. What we don't have is the framework within organisations, the local yardsticks. Organisations are not very good at articulating the expectations of their workforce. You go to the trust here, and they would struggle I think to say right this is a full set of our expectations of view. They can produce job specifications and things like that, but they are really dry and don't say anything at all about the organisations expectations of you. I would certainly use those external things, I would say we have these external things to go on, what I think we would struggle to find are the internal yardsticks by which I could measure the needs of my staff. Where they are in terms of the development that they would require, in terms of doing the job or in terms of developing their career. But again it is a leadership issue, how many ward managers are empowered to do just that? Both through their own knowledge and through the organisation giving permission to do that, I don't know. It seems like the organisation to say well if you haven't got the skills then that's your fault. You are stuck on nights, well is your fault you shouldn't have stayed on nights.

F

and remember when they what the health service we had a system an IPR system, which had very clear management objectives which I had to meet. My performance was measured against those objectives, and at that point annually it may have been determined that I had a training need. But that was a kind of added on bit. Now that I have got to the university we have a system which is called personal development review and the focus of the review is mainly on what are my training needs. It is that the kind of system that you talking about?

L

I think that would be useful, and it certainly within nursing, we have the legacy of general management and the yuppie culture, this think that it is about hard managerial, certainly the NHS as a whole, in the Eighties and Nineties were like that and allowed organisations to develop in that way. What they haven't done although there has been a lot of evidence that has been a lot of research to show that is moving on to the more personal stuff like expanding clinical supervision to include opportunities for people to elucidate their personal development needs. I know that some people and the dismissive of systems like that because they are approaching it from an organisational point of view. If I could just disclose a bit, from my own personal development thinking, I was first a ward manager in 1991, I was a young ward manager and I was placed with an old lag who was shuffled off to some job in community or somewhere. It was 1991, and you know what the time was like, there was a good feeling, it was a small hospital that I was working in, there was a feeling that we wanted to change things. There was a big focus on general management things like clinical grading happened, there were G. Grades and then they became ward managers. You know I'm not a charge nurse now I am a ward manager. I went along with this, and got very heavily involved in the managerial culture. That lasted for about two years or so. I began to realise that that definitely wasn't all of the answer. I realised that this was in fact a very very poor way of looking at that. If I could have done it again I would have done it very differently. I would have used the more inclusive approach bringing clinical management and clinical leadership together. If that was happening to me, you can be sure that it was happening to an awful lot of other people at the time. We still have a lot of ward managers, we have a

plentiful supply of ward managers. I note now that there is a proliferation of lesser grade jobs that have the title of clinical leader or something like that.

F

yes and there is a strange thing I have noticed as well, because I still do some time and clinical area. And it has migrated towards clinical supervision, and it's mostly with people who have the title of ward manager, clinical manager.

L

I know that some people get it quicker than others, but eventually they must realise that you have got to have a full set of tools in the kit, to do that I job. You know you can take an engine in and out like with one spanner, you need a full set of tools, plugs spanner screwdriver the lot!

F

my surprise in doing all of this is in realising how talented they all are. How much knowledge they have got. They are absolutely bursting full of dynamism, and very frustrated that nothing is happening.

L

yes that's what I'm saying, that's my argument about their being a lot of potential and everyone. What we don't have are readily available channels for people to go down. And if the channels were created, going back to this passive, active sort of stuff, you could massively expand the passive channels. Some people would take more interest like ward managers with a bit more acumen, a bit more confidence about themselves. But I don't think you would get as much of a result as if you scrapped the whole lot and went in for a more assertive approach. I don't like these sorts of things that, every time that something comes up you get these, the NHS Alliance & all these regional people producing reactive programmes. You know, this has happened, let's put on a jolly event about it. That really pisses me off, because you know there has been a lot of resource put into things like that.

Appendix 3 - Index system

Q.S.R. NUD.IST Power version, revision 4.0.

Licensee: Frank Mitchell.

PROJECT: EdD, User Frank Mitchell, 4:41 pm, Sept 14, 2002.

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(F) //Free Nodes
(I) //Index Searches
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(T) //Text Searches
(T 1) //Text Searches/TextSearch
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(T 28) //Text Searches/TextSearch219
(T 29) //Text Searches/TextSearch220
(T 30) //Text Searches/TextSearch221
(T 31) //Text Searches/TextSearch222
(T 32) //Text Searches/TextSearch223
(C) //Node Clipboard - 'TextSearch223'
(3) /Attributes
(3 7) /Attributes/Confidence
(3 1) /Attributes/Motivated
(3 6) /Attributes/Team Player